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THE SOCIAL SIDE OF MEDICAL PROGRESS*

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IN DISCUSSING the social side of medical progress, I shall deal not so much with factual matters as with interpretations. Interpretations are inevitably opinions. And you may not agree with my interpretations. My excuse for presenting them on this occasion is simply this: it is as well at times to draw back a little from the details of immediate and practical projects and in contemplation to view medical and social situations in broad perspective, to see trends, directions and dimensions. Such a procedure serves to bring these matters to the front so that for a few minutes we may think about them in a way that is essentially detailed and philosophical.

Viewed in this way the feature that shows as peculiar to the present period is the rapid shift and change of long established social institutions. As we watch these changes, the realization is forced upon us that the body of society is a delicately integrated entity just as is the body of man—so closely knit and interdependent in its parts that a change in any one must necessarily result in a change in all other parts, in a total readjustment.

Thus if medical discovery is made and applied to the saving of lives, there must follow a reorganization of society as a whole. The saving of life results in a change in the age structure of the population. The change in the age structure of the population upsets the balance of established institutions and necessitates social and economic readjustments.

The consequences of somewhat less than a hundred years of not too intensively applied preventive medicine—mostly an impersonal sort of medicine—have been the enormous diminution in the diseases and deaths of early life—the acute infectious diseases and infant mortality. As a result, the average length of human life has nearly doubled in this period. The age structure of the population has shifted and is still shifting. The facts and figures are familiar to you: In 1900 there was one person of sixty years of age or over in every twenty members of the population; in 1930 there was one in every twelve; and by 1960 there may be one in every six—one-sixth of the population sixty years of age or over. Here is the greatest change of its sort that has ever affected civilization. In the past there have been changes from war and pestilence but they have been from loss, not saving, of life. Here, growing from medical advancement, is a social and economic problem of vast magnitude in which the first efforts toward solution have taken the forms of social security legislation and old-age pensions; but these efforts do not touch upon the real problems of old age and retirement in an industrial civilization. They do not touch upon the consequences to medicine.

It is axiomatic in our field that as one disease diminishes, others rise to take its place. As the incidence of tuberculosis, typhoid, dysentery and smallpox go down, cancer and diseases of the circulatory system rise correspondingly. The change in the leading causes of death in the last thirty-eight years is commonplace knowledge.

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So far the physician sees clearly; but sometimes I think he fails to see that medicine itself is one of the institutions affected by the changes that are brought about. Completing its circuitous course through the social structure, the change eventually comes back to medicine. A readjustment must be made there. Medicine does not stand alone; it is an integral part of society. It must either make the necessary adjustments to change or be swept aside. Readjustment—continual readjustment—of medicine is the inevitable consequence of medical progress.

Readjustment is disturbing. We tend to resist it; and resisting it we sometimes get out of step with progress and are left behind. Such resistance is futile; its consequences are destructive.

In the face of such change there appears one of the peculiarities of medicine: the failure to realize that it must change as society changes. It has been one of the most characteristic features of the physician of all ages—and the present is no exception—to hold in a certain arrogance the belief that the form of medicine, the principles of medicine and its practice, are vastly superior to those of all preceding ages; that they are the ultimate, beyond which there can be no constructive change.

In short, the progress of medicine has always showed this: Medical thought has crystallized on a line of endeavor. This line has been followed long after its usefulness has passed. Medicine has then, to the great cost of the doctor, been stopped and redirected to move in another line until that in turn has lost its usefulness—until the form of medicine was no longer suited to the time and was therefore discarded by the public. This same process occurs in government as well as medicine; a regimen goes along getting more and more out of step with social needs. Then there is a war, a revolution, and a new start is made. This process repeats itself over and over.

Now what I say tonight is essentially an indictment of the inertia of modern medicine. And in so doing I ask you to remember that inertia does not apply alone to things that are stationary; there can be inertia also of movement. Medicine and the physician, following a course that has been set, stay fast to the direction with fixed attention and dogged disregard of the fact that goals may shift, that situations may alter; that the direction of the movement may no longer lead to the desired goals. In the past this phenomenon has occurred time and time again and medicine has dwindled out to futility. The same situation is, I think, developing today. And medicine, for all the apparent progress of medical science, can dwindle out again to futility. The medicine of today may be vastly different from the medicine of the past but the fact remains that the social and sociological forces that guide it, operate upon it today just as they did in the past.

The great danger that I see to the practice of medicine today lies in the very thing that has given medicine its modern preëminence: and that is science. The physician has committed himself to science. He stands or falls with it. My indictment tonight is against this science—a science that has led the doctor to neglect the equally fundamental and non-scientific social aspects of medical practice—those things that we sometimes sum up as the art of medicine, a thing about which the younger generation of physicians knows so little. The doctor, in making a fetish of science, may find himself worshipping alone. He will unless his medical practices are changed continually to suit precisely the society in which he lives.

The doctor of America in the eighteenth and early nineteenth centuries was not a scientist. He was a public-spirited man whose medicine suited the times. He was a social leader, embodying the rare combination of medical practice and sociology. He was arrogant when he thought of the lack of knowledge of his predecessors—sometimes of his own contemporaries. But this temporal arrogance is always a characteristic of the doctor. We today look with pity, mingled with contempt, on the practices of Benjamin Rush. It was Rush, you will remember, who made that pathetic statement: "Medicine is my wife and science my mistress." It was Oliver Wendell Holmes, with the arrogance of the succeeding generation, who commented: "Medicine may be his wife and science his mistress, but it cannot be shown that this breach of the Seventh Commandment was of any advantage to the legitimate recipient of his affections." Yet, in spite of his lack of science, Rush as practitioner and medical leader has no equal today.

It is that very matter of science that occupies my attention tonight. The tenet of the young physician today is too apt to be the reverse of that of Rush. He could almost say: science is my wife and medicine my mistress.

The reason for the mode of thought that pervades medicine today is not hard to find. The acquisition of knowledge must of necessity come before application; it has the primary place both in time and importance. In the last hundred years, with the introduction of the exact sciences into medicine, medical research has yielded some of the most beneficial knowledge that the human race has ever acquired. Enthusiasm has grown high and a mode of thought crystallized. The science of medicine has been elevated; the practice of medicine—the art of medicine—which is not a science and probably never will be, has been subordinated.

The emphasis (or overemphasis) on research has resulted in the development of an aura of sanctity about research. The acquisition of knowledge has received and still receives a cultivated regard amounting almost to a veneration, and one out of all proportion to the regard given to the application of the results of research. We seem to look only to the future—to put the whole emphasis of our endeavors on finding the means for curtailing disease without putting into use, to the fullest extent, the measures we have for those who need them now. This mode of thought, scientific research—the search for novelty, the new—is inculcated in the medical student and hence in the physician; it has given a direction to medicine. And the movement has developed an inertia so that medicine cannot readily turn to new directions, although those directions are clearly indicated.

Medical science, gentlemen, is not medical practice. The great benefits from the application of preventive medicine that so dominate the public mind today are again not those of medical practice. These matters are science and being science they do not require the participation of the practitioner. Any aspect of medicine that has been reduced to an exact science needs merely medical technicians and not physicians for its accomplishment. Such is the case with much of sanitation. Such is the case also with many of our diagnostic tests. At one time it required the consummate skill of the physician to determine in some cases the presence of syphilis; now a far more accurate diagnosis is made by a technician in the laboratory. When—and if—medicine becomes an exact science we shall no longer need the practicing physician. Until it does become an exact science, then we not only need him, but we should grant him his due and proper importance.

The practicing physician is not a scientist. He is, if he really practices medicine, more, far more, than a scientist. He is an artist. He does not deal with the controlled and limited matters of the laboratory; he deals with human beings. So long as the human mind in its full ramifications remains beyond an evaluation with scientific precision, then the practice of medicine must remain an art. So long as medical practice involves the personal contact of physician and patient then it is the art of the physician which must establish the necessary bond. This is very different from medical research. It is, in many ways, more difficult. It involves not only intelligence and skill, but also qualities of personality unnecessary to the research worker. This personality element in medical practice has been—if not openly at least by indirection—scoffed at by the scientist or ignored.

There are two sides of medicine and we tend to confuse them. On one side is the medical research worker searching for knowledge; on the other is the practicing physician applying that knowledge. Far oftener than not the research worker is a poor physician. There is more to medical practice than the mere knowledge of medical fact. There is the old and true adage that "you can't carry an experiment bleeding from the laboratory to the bedside." The medical research worker and the practicing physician each has his proper and equally important place.

And yet with the emphasis placed upon science, with the public believing in the marvels of science, with the kudos of science, the physician has very naturally wished to believe that he was a scientist.

In the first flush of the triumphs of the application of science to medicine, it appeared that all the problems of medicine were to be answered and that medicine at last was destined to become as exact and impersonal as engineering. In consequence, to the eventual great detriment of the practice of medicine, our medical education was changed. It adopted the precise

methods of science. It built its structure on the laboratory as a foundation.

Trace with me the broad steps in the change in American medical education. A century and a quarter ago French medicine went through one of the periodic changes of direction—a drastic change in a revolution. The old staid and formal dogmatic teaching broke down to give way to an active clinical investigative type of medicine. In Germany the change came a little later but it was mainly German medicine that ours followed. A little over a century ago Germany, following the Napoleonic wars, was in the throes of a wave of idealism and romanticism that denied in the medical schools factual investigation and permitted only speculation. It was one of the extremes of the pendulum movement of education. Then it swung the other way; by the middle of the century German preclinical medicine had been founded by Johannes Müller. It was around him that the great school of Berlin was developed. His pupils, including Virchow, give the roster of the famous teachers and investigators of Germany. Almost without exception, and this includes Müller, they were men with enormous social interests. Virchow, you will remember, was as fearless and fiery in his political activities and his denouncements as he was in the classroom. The best of German medicine was gradually brought to America. The part that caught and held attention was the research aspect. At first the leading schools in this country were famous for their clinical teachers. The preëminence of Johns Hopkins in the closing years of the last century, and the early years of this century, was based on its great clinicians. Today, with the continual swing of the pendulum toward research, the prëeminence of a school is judged, not by how well it trains doctors for the practice of medicine, but upon the eminence of its researches. The chairs once occupied by great clinicians with wide social interests and wide social influences are too often filled by scientists out of touch with the real problems of the practitioner. Few great scientists have been outstanding physicians. Harvey, who described the circulation of the blood, was a bad therapeutist; Koch, to whom we owe the conception of the bacterial cause of disease, gave up practice; and Pasteur was not even a physician. Formerly, students in our schools were trained to be socially beneficial. Now they are trained too often with the apparent intention of making laboratory investigators out of them and that in spite of the fact that medical practice is a social application. Today we train too often, not physicians with all the significance of the term, but instead, we train bedside pathologists.

Medical training is being divorced from medical practice; preclinical training is being sold out to educators who are not even physicians. There are those who wisely think that the student from the first to the last of his four years of training should be in contact with physicians and be taught clinically. Instead, there has grown up the whole division of subjects called preclinical. If they are preclinical they should be premedical. If they are taught in medical schools they should be taught, not as if in training for the Ph.D. degree, but instead constantly from the medical point of view and by physicians. Our grandfathers had only two years of medical training; it was almost entirely clinical; we are contemptuous of their deficient education. Today we have four years in our schools, but mostly we still have only two years of actual training in medical practice. The expansion has come from the addition of preclinical subjects taught in a detail and with a detachment wholly unnecessary to medical practice.

The emphasis upon science, upon the laboratory, has extended down even into the premedical field in the college. The selection there is made upon the basis, not of socially-minded individuals who would make good practitioners, but upon the basis of aptness in the laboratory subjects. The class of men who enter our medical schools, at least from our large Eastern colleges, are today, as potential material for social leadership, distinctly inferior to the young men from the same colleges entering law and business. We are turning away good men because no matter how great their ability might be as practitioners—they show no aptitude for the technic of medical research.

There is today a greater need for socially-minded, public-guiding physicians than at any previous period in medicine. The applications of sanitation are wiping out the infectious diseases of early life. In consequence, as I have mentioned, the average length of life has changed and with it the leading causes of mortality. The diseases that come to the front in

the modern medical readjustment cannot be cured or prevented by impersonal science. They can be controlled only by the close and intelligent coöperation of the individual members of the public with the physician. Obtaining this coöperation is a vastly different matter from acquiring the knowledge of how to prevent or treat the diseases. It is not medical research or science; it is the practice of medicine in its broadest service of a social leadership.

All achieved medical advancement consists of two distinct parts—and they are distinct. One is medical research in the acquisition of the knowledge of means by which suffering can be assuaged and diseases cured or prevented. That is the part today that receives the interest and the emphasis both in most of our schools and certainly in the minds of the public. But this part alone, this knowledge gained from research, accomplishes none of these things. They are accomplished and true advancement achieved only when the second necessary part is fulfilled. And the second part is putting the knowledge into application. Application is then for all practical purposes as important as discovery. Application belongs to the practice of medicine. Today unquestionably, with our enormous accumulated knowledge, there exists a wider gap between what can be done to control and prevent disease and what is being done than at any previous time in history. This fact is a grave indictment against the practice of medicine. It is the result of following a set direction of medical progress with no consideration of changing social conditions.

The great resultant danger to medical practice lies here. The public is beginning to realize the gap—the failure of application. The recognition will grow as long as these matters of application—crying in their need today—remain, if not in the contempt of the physician, at least not in his highest regard.

The social worker of today knows that the greatest, indeed probably the only possible field of social betterment, is offered by medical application. Some aggressive lay groups stand ready to raid the medical field for its unapplied potentialities. With the natural reaction of newcomers to the field—unacquainted with its ramifications, but sensing its deficiencies—they assume that there is something basically wrong with the form of medical practice. Their first inclination is to remake the form of medicine. Today the doctor must take his choice—lead or be led.

There is tremendous danger from this direction. Public opinion determines the condition and future of medicine. Today the public has an influence on social affairs and upon medical affairs greater than at any other time in history. But the actions of the public, unless guided, are always destructive, never constructive. People tend to pull down everything to the average level. Advancement, construction, is not made by great numbers, but by great individuals.

The only chance for medical leadership from the physician is to cultivate throughout our public a realization of what medicine can do; and to cultivate a coöperation between the public and the physician to do the things that medicine can do. In the last analysis it comes down to this: the shaping of public opinion to a high regard of medicine and of the practicing physician as its prophet. Unfortunately too much of the shaping has been to divert attention to the marvels of medical science and the deficiencies of medical practice.

It isn't what medicine does, it isn't what science discovers, that gives the necessary high public regard to the physician. It is what the public thinks and believes. And the public attitude reflects the doctor's own opinion of himself. If he thinks of himself as a scientist, he will be treated as one; he will be held in the same regard in which the physicist, the chemist, and the engineer are held. If he believes, as he should believe, and shows that he is a leader toward social betterment, worthy of public regard, he will receive that regard. These are matters of emotion and not of reason.

The physician, in casting his lot with scientific research, stands and falls with it. And he has chosen an uncertain support. We have grown to believe in the ruggedness, the permanence, the necessity of medical research. In so doing we delude ourselves. As a matter of fact, medical science is one of the most highly cultivated aspects of civilization. It can flourish, even exist, only under the most favorable conditions of civilization. A social disturbance destroys first of all medical science. It has happened in other countries and it can happen in our own just as easily. A little over a hundred years ago, as I said, there was no medical science in Germany.

The country was in the throes of a wave of romanticism and mysticism. Then in half a century Germany raised herself to world preëminence in medical science, set the course which we follow today. And then in the present century, under changing social conditions, medical science declined in Germany—it is disappearing; it has already gone in Russia, Italy and Spain. We still have it in our country. But it remains at the mercy of social change.

The permanent basis of medicine is not its research, but its social application—its practice. That has persisted in every age; it will endure in spite of our neglect of it. It can and will rise up to great importance if our public is taught to respect it.

In looking toward shaping public opinion we see today a situation such as has never existed before. We have a tremendous literate but uneducated public bound together by the marvels of modern communication—the radio and the printed page. The means for shaping public opinion exist as they have never existed before. The consequences are, at one and the same time, enormous dangers and enormous possibilities for doing good. The good or bad will depend upon the leadership and the ideas and ideals of the propagandists in medicine.

This field of propaganda is one in which I have been particularly interested for the last ten or twelve years. And here again as in the matters about which I have been talking I have definite ideas which are contrary to many of the present tendencies. These ideas are based on the belief that I have reiterated here, that the regard in which the physician is held is engendered in emotion—not in reason. The general tendency in medical propaganda by the physician and his organized groups is to tell of the glories of medical research—the new discoveries in medicine—to tell of medical knowledge. Years ago the physician carefully hid his knowledge from the public—made a mystery of his arcanas—wrote his prescriptions in Latin. He surrounded his calling with a glamor. Then there came a change, a reaction. The physician put aside the mystery. The measures of public sanitation could be put into effect only by the intelligent aid of the public, particularly in passing laws. He had no secrets left from the public—and he shouldn't have. But he went even further—he not only let the bars down, he let his hair down as well, and began in his new and rigorous scientific attitude to debunk the art of his own calling, to divest it of all its appealing emotional qualities. Instead of shaping public opinion he attempted to give the public medical information. Medical discoveries have become news, news about which lay writers express opinions, news which the public discusses from the factual point of view critically. It is a case of the dangers of a little knowledge. Far too often the propaganda lacks the one thing that propaganda should have and that is the cultivation of a public regard of the physician and of his calling—a regard that makes him something more than a scientist in search of novelty—that gives a veneration that the physician deserves and must have if he is to guide the American people.

My talk tonight is rambling in spots; it lacks the vigor and directness of the legal brief. It does so because these are things over which I am emotionally aroused. To my mind what I have been discussing is the decline of American medicine. On one side is research commanding public veneration; on the other is medical practice, a fair target, unprotected by public regard from the economic experimenter, the sociological reformer and the political opportunist. What I ask is not any decrease in medical research, indeed every increase, but that medical research and medical practice be recognized as distinct but equally important, equally skilled, equally valuable parts of medicine as a whole. I ask that we may recognize that a physician may be a great doctor without doing original and basic laboratory investigations; that such research belongs to the research investigator and practice to the practitioner. And most of all, I hope that we will go back to training our medical students clinically by great clinicians to be great clinicians.

MEDICINE AND THE LAW*

THE HONORABLE JOHN M. GALLAGHER
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THE privilege of addressing this distinguished gathering is one that any citizen would welcome. It is one that any member of the bench or bar should appreciate. It affords the opportunity of exchanging views with the members of a great profession upon questions concerning which you, as members of the medical profession, and I, as a member of the legal profession, are similarly interested.

We speak of law and medicine as learned professions. We have learned lawyers and learned physicians of whom we are justly proud. Law and medicine are professions, which mean the common obligation of work to be done under the domination of the idea of excellence. The financial reward, if any, acceptable as it may be, is not the dominating idea. Law and medicine alike lure us on with those ideals of excellence, that we may well give them the best that any man can give.

Fate seems to have thrown the professions of law and medicine into fruitful contact, almost since their very beginning. The contact arises from the fact that both deal with the ills of human beings. And while the art of science of medicine is the older and has existed ever since organized society came into being, law, as a form of social control, has affected medicine.

In the modern legal world, the contact between law and medicine is greater, because of the limitations imposed by society, through law, upon the exercise of the profession, the manner of its exercise, and the use which law makes of medicine in the solution of some of its problems.

A trite definition of the physician or surgeon states "that he is one who is experienced in the art of healing or curing the disorders of the human body."

We need not discuss the historical development of the medical profession, or the constant broadening of social control over it. The profession itself has been chiefly instrumental in securing, in its own interest, and in that of humanity, the strictest regulations. It aims to weed out charlatanism and quackery. From the earliest times, courts have upheld the right of society, through its legislative bodies, to regulate the practice of medicine and surgery. These regulations have had as their chief aim the protection of public health—which is always a matter of social concern. The methods of achieving this, which courts have upheld, have dealt with educational requirements and standards, aiming to establish a minimum standard of skill and learning, as a prerequisite to the exercise of the science or art of healing.

The Court of this state, as early as 1889 (State vs. Fleischer, 41 Minn. 69), held constitutional an act passed by the 1887 Legislature regulating the practice of medicine, the licensing of physicians and surgeons and providing punishment for violations of the act. Holding the law constitutional Justice Collins speaking for the court said:

> "From the spirit and object of the act, plainly seen in its several sections, it is obvious that the lawmakers intended to establish a high standard of qualification and fitness for the medical profession, whereby the people might be protected from ignorance and quackery."

Later in State vs. Broden (181 Minn. 341, decided Oct. 10, 1930), the Supreme Court of this state held that the basic science act is not violative of any constitutional provision, either state or federal. Only recently in State v. Mielke, (277 N. W. 420, decided Feb. 4, 1938), the court sustained an information against a person who was endeavoring to circumvent the provisions of the basic science act by means of advertising and other quackery holding that the practice resorted to was a violation of the law.

Generally, the law has protected the public by holding the practitioner to a high degree of professional and ethical responsibility. This applies to the practice of medicine, or any of the other schools of healing, whose graduates are entitled to the license of physician and surgeon.

The law provides that the medical board may

*Read at the annual meeting of the Minnesota State Medical Association, Duluth, Minnesota, July 1, 1938.

refuse to grant a license to or may revoke the license of any person guilty of "immoral, dishonorable, or unprofessional conduct" but subject to the right of the applicant to appeal to the court on questions of law and fact. The words "immoral, dishonorable, or unprofessional conduct" are defined in the act to mean:

(a) Procuring, aiding or abetting a criminal abortion,
(b) Advertising in any manner either in his own name or under the name of another person or concern, actual or pretended, professional superiority to or greater skill than that possessed by fellow physicians or surgeons . . . ,
(c) The obtaining of any fee or offering to accept a fee on the assurance or promise that a manifestly incurable disease can be or will be cured,
(d) Wilfully betraying a professional secret,
(e) Habitual indulgence in the use of drugs,
(f) Conviction for wilfully violating any narcotic law,
(g) Conviction of offense involving moral turpitude,
(h) Conviction of a felony.

It is evident, therefore, that while the standard of ethical conduct is high, it is not rigorous or unfair. Certainly no layman would want to trust a healer who did any of the acts denounced by the statute. It is also fair in allowing the courts to review the acts of the Board of Examiners, who, after a hearing, have deprived a physician of his right to practice. In reviewing the evidence presented before the board, the courts adopt the principle which applies to all bodies exercising quasi-judicial functions. Their findings will be upheld if there is any substantial evidence to support them. When there is conflict of evidence, the courts will not endeavor to resolve the conflict in a manner different from that of the Board.

When the law steps in to hold the physician accountable, in damages, for negligent acts in the exercise of his profession, it is also fair. It requires no impossibilities. It does not even require an abstract standard of skill. It requires a skill limited in time, and in character. Briefly stated, the fundamental principles governing liability for negligent acts on the part of the physician or surgeon are as follows: The physician is not a guarantor or insurer of cure. By accepting employment, he merely undertakes to use the average skill of other physicians in the same or similar localities. A mistaken diagnosis does not constitute malpractice, in the absence of negligence.

The following quotation from a case recently decided by the Supreme Court (Yates v. Gamble, 198 Minn. 7) is a good summary of the law on the subject:

"A physician and a surgeon is not an insurer of a cure or a good result of his treatment or operation. He is only required to possess the skill and learning possessed by the average member of his school of the profession in good standing in his locality, and to apply that skill and learning with due care."

This summary indicates that in modern times, the law takes a reasonable attitude towards the practitioner of the healing act. It does not punish him for failure to cure, in the absence of negligence. The law has not always been so charitable. The oldest code of the world, the Code of Hammurabi of Babylon (dating from 2250 B. C.) while doing nicely by the physician by regulating his fees, punished him severely for his failures. Here are some of the provisions of that famous code, taken from a new translation (J. M. Powis Smith: The Origin and History of Hebrew Law, pp. 211-212):

"215 If a physician makes a deep incision upon a man (*i.e.*, perform a major operation) with his bronze lancet and save the man's life; or if he operate on the eye socket of a man with his bronze lancet and save that man's eye, he shall receive ten sheckles of silver.
"216 If it were a common man, he shall receive five sheckels.
"217 If it were a man's slave, the owner of the slave shall give two sheckels of silver to the physician.
"218 If a physician make a deep incision upon a man with his bronze lancet and cause the man's death, or operate on the eye socket of a man with his bronze lancet and destroy the man's eye, they shall cut off his hand.
"219 If a physician make a deep incision upon a slave of a common man with his bronze lancet and cause his death, he shall substitute a slave of equal value."

The physician is a valuable man to the court. This fact was recognized early in our jurisprudence. Physicians like to quote the following statement made by Mr. Justice Saunders in an English case in 1553, justifying the employment of a medical expert:

"If matters arise in our law which concern other sciences, we commonly apply for the aid of that science which is concerned therein, which is an hon-

orable and commendable thing in our law, for thereby it appears that we do not despise all other sciences than our own but we approve them and encourage them as things worthy of commendation."

Thus the help of the physician has always been welcome in courts. That prejudice has arisen against the testimony of the physician, when he appears as an expert, is common knowledge. I think the prejudice may be traced to the great divergence between the opinions of experts in mental diseases. They occur in important will cases, and in criminal cases—under the plea of insanity. The difficulty in criminal cases is often traceable to the difference between legal and medical concepts of insanity. In law, insanity implies inability to recognize the wrongfulness of an act. Our concept is based upon outmoded mental science or psychology. And when the physician and the lawyer speak of insanity they do not speak of the same thing. With the physician and psychologist, mental derangement may be entirely unconnected with any doctrine of responsibility. Moreover, according to the tenets of modern psychology, an ability to distinguish between the rightfulness and wrongfulness of an act, does not necessarily imply either wilfulness or responsibility. The psychopathic personality, which expresses itself in criminality, is the very embodiment of irresponsibility to the physician. And yet, in law, we hold him responsible.

I believe that in a great majority of cases difference of opinion between medical men arise for the same reason that differences arise between other experts. Lawyers are proverbially in disagreement, not only as to the meaning of decisions, and such differences are easily explainable when we consider how laws are enacted, enforced and interpreted. A legislature composed of two branches and consisting of men gathered from every nook and corner of the state assemble every two years for the purpose of enacting new laws, repealing old ones and amending others. It is not strange that errors and inconsistencies occur. The drafters have different political, economic and social views. Occasionally, a joker goes in. Is it a wonder that confusion and uncertainty exists? Is it a wonder that errors are made? To me the only wonder is that more errors are not made, that greater inconsistencies do not result.

Some of these laws eventually reach the courts for interpretation. The courts are as a rule made up of men of different political, economic and social views. They are even composed of a varied degree of ability and intelligence. It is only natural therefore, if they are honest, that they should sometimes disagree as to interpretation. And, fortunately, under our system of government each has a right to express his views as to such interpretation.

I hope that the time may come in this state when medical experts may become "arms of the court" rather than "aids to partisans." That is partially possible now under our compensation law. And still in such cases the expert must testify with full knowledge that his compensation must eventually come from the coffers of the employer.

Law both through legislation and court interpretation will continue to coöperate with the physician, as it has done in the past, to help him to carry on his noble calling. It will call upon him for aid when necessary and will aid him when occasion calls. Each profession needs the other. The public needs both. Each should, and, I am sure, will, in the future as in the past, aid the other.

PROFESSIONAL CO-OPERATION IN THE PUBLIC INTEREST*

STANLEY B. HOUCK†
Minneapolis, Minnesota

I HAVE been wondering why my talk to you has been placed between that of the Chief Justice of Minnesota and that of my very good friend, the president of your Association. I am not entirely clear whether I am intended to be the valley between the hills or the heights between the valleys.

I am especially pleased to be here this morning and to have an opportunity to speak to you. Before I say anything else I want to express the pleasure I have had during the past year, as a member of a committee of the Minnesota State Bar Association, in working with your Committee on Coöperation with the Bar, of which Dr. Branton of Willmar is chairman. These two committees of the Bar and of your Association have not only had a most delightful series of personal contacts and conferences but have laid the foundation and done much of the spade work for a more healthy relationship between the two associations and for a better regard by each profession for its obligation to the public and for the basic public interest. The work of these two committees is just begun. I do not know what you have done to continue your committee for another year. I hope you have made the necessary arrangements to do so.

I like to think of the medical and legal professions as representative of the highest possible type of professional existence. Each is, I am confident, freer from the taint of commercialism than any of the other so-called professions. In saying this I am not disparaging other professions, since they are usually by the very nature of things more intimately and inherently associated with commercial undertakings. The relationship of the medical and of the legal profession to the public is usually a more directly personal relationship than can be true of the other professions. This is true of the medical profession even more than it is of the legal profession. You deal only with persons and their ailments. The legal profession deals also with the problems and difficulties of natural persons but in addition deals with those of artificial persons such as partnerships, associations and corporations.

What the courts have said regarding the basic characteristics of the legal profession is likewise true in most respects of the medical profession.

The Supreme Court of Washington has said:

"The practice of the law is a personal right, and, that the public may not be imposed upon by the unworthy, the law requires that those engaged in practice shall be men of good moral character and with certain qualifications and a degree of learning to be ascertained by the agents, not of the courts, but of the whole people speaking through the legislative body. The right to practice law attaches to the individual and dies with him. It cannot be made the subject of business to be sheltered under the cloak of a corporation having marketable shares descendible under the laws of inheritance. One engaged in the practice of the law is subject to personal discipline for misconduct and to penalties for violating the ethics of the profession that could not possibly attach to a corporate body."

Justice Cardozo of the U. S. Supreme Court, when he was a member of the highest court of New York, said:

"Membership in the bar is a privilege burdened with conditions. The appellant was received into that ancient fellowship for something more than private gain. He became an officer of the court, and, like the court itself, an instrument or agency to advance the ends of justice. His coöperation with the court was due, whenever justice would be imperiled if coöperation was withheld."

From this, the conclusion is inescapable that our professional existence depends upon the public need. The license given us to practice our professions is not given to confer an advantage upon us as individual members thereof but to afford to the public whom we serve a necessary protection from exploitation and other abuses. The requirements of education and character are similarly imposed. They become more exacting as the public need for greater knowledge, greater training and greater skill develops.

I may summarize the fundamentals of our professions by saying that the prerequisites to a license to practice law or medicine are those

*Address given at the annual meeting of the Minnesota State Medical Association, Duluth, Minnesota, July 1, 1938.

†Chairman of the Committee on Unauthorized Practices of the Law of the American Bar Association.

things which the public conceives to be necessary from time to time for its protection. The problem which confronts the members of each of our professions is how to so conduct ourselves in our professional relations that we shall supply what the public needs and demands without allowing such evils to arise as will cause the public to relax and liberalize its requirements preliminary and prerequisite to license to practice.

There is, of course, a distinction between the place of the legal profession and that of the medical profession in relation to the processes of government.

The principal, the effective distinction, between a lawyer and all others, whatever their walk in life, lies in the lawyer's relationship to the judicial department of our government and is largely a matter of his morals and character and his special education and training in the field of the law and his resulting knowledge of the rules of law, the principles of justice and the means and manner of their suitable administration. To round out the difference, the lawyer is an officer of the court and a direct agency and instrumentality—an integral part—of the judicial department. There is imposed upon the lawyer certain inescapable duties and obligations not placed upon anyone else, in respect of his every act and conduct, whether it affects himself, his client, the general public, or the court.

I pause, to digress momentarily. I hope you will not think, because of what I have just said, that each of you, as members of the medical profession, has no public duty to perform in respect of the administration of justice. The original basic obligation to do justice rests upon each of us without regard to the existence of courts or what it may be their province to do. It rests in the first instance upon each of you in the conduct of your profession and upon every other business and professional man. If all of us in our contacts and transactions with those with whom we deal did mere justice, as we are so obligated and in duty bound to do, there never would arise the occasion to apply to the courts for their aid to see that there is done the justice we have failed to do.

You are not a public agency, nor a part of any of the divisions or the departments of our local or national governments. You are not an instrumentality concerned with the administration of justice; nor licensed to practice law as an officer of any courts.

However, to an increasing degree, especially of late, members of the medical profession are coming more directly into contact with the processes of justice. The more intelligent administration of the criminal laws is making more frequent and continuing demands upon the medical profession for a saner determination and appraisal of the causes and degrees of criminal culpability and the suitability of the punishments and restraints about to be imposed or released. The astounding increase in personal injury litigation has made similar rapidly expanding demands in the field of civil litigation.

As the lawyer functions as a part of the judicial machine and as an aid to the court and to the public in the administration of justice, so does the doctor contribute to the doing of justice by the character of testimony and other forms of evidence he presents both before courts and before our administrative tribunals such as Workmen's Compensation Commissions.

As I have said, there is a basic duty on the part of each citizen to do justice. That duty, obviously, is not less in the case of members of either of our professions than in the case of the ordinary citizen. It can only be a greater obligation imposed because of our professional status. This imposes an added responsibility for seeing that the processes of justice, so far as we have anything to do with them, are not distorted, exploited or turned to the public injury or disadvantage.

Because members of the legal and medical professions are having more frequent dealings with each other in matters legal in character, the two professions inevitably must concern themselves more seriously with the problems arising therefrom.

The lawyer for the plaintiff and the lawyer for the defendant each turns to a doctor for testimony. With the plaintiff attempting to establish one state of facts and the defendant to prevent the establishment thereof, or to establish a different state of facts, a situation exists which provides fertile ground for serious abuses and presents problems calling for action not only by the individual members of the two professions but for the coöperative attention of both professional groups.

Probably the most common problem which

arises is the all too prevalent alliance between attorney and doctor. A continuing relationship —sometimes almost in the nature of a partnership or joint adventure—between lawyers who usually serve the plaintiff and a doctor who usually testifies on behalf of the plaintiff represented by the particular lawyer, cannot be viewed with equanimity by either profession. Nor, of course, is the relationship between the lawyer for the defendant and the doctor ordinarily and customarily appearing as a witness on behalf of the defendant in any better case. There are many abuses in this relationship. Certain attorneys almost invariably send all of their clients to certain doctors for treatment, for observation, all in anticipation of litigation and testimony. Attorneys for defendants do substantially the same thing.

It seems unnecessary to state that doctors employed under such circumstances are confronted with conditions not favorable to proper and ethical conduct either as doctors or as witnesses. If we add another factor and let the doctor's compensation be contingent or its amount depend upon the outcome of the case we have cause for the gravest concern.

Not only do lawyers send their clients to particular doctors but frequently the process is reversed and doctors urge their patients to go to particular lawyers for the purpose of collecting damages for physical injury. Sometimes doctors indicate that only thereby will they collect their bills.

In addition are the various forms of misconduct and abuse of the public of which individual members of each profession are guilty. Just as there are many lawyers who are known as "plaintiffs' lawyers" and "defendants' lawyers" so there are doctors who are generally known in the community as those from whom can be obtained testimony most appropriate to the plaintiff's case or most appropriate to the defendant's case. The eradication of such individuals from both professions is an obligation of each profession which calls for prompt action.

Nothing can be more serious in its effect upon the public than to have witnesses, and especially expert medical witnesses, participating in the "build-up" of a case, and interested in the amount recovered either because of participation in its planning or because their compensation depends upon a successful outcome.

The responsibility for such things can not be assigned alone to the individual. They can not be passed off by a shrug of the profession's shoulders and an attitude of indifference.

Both professions have imposed upon them the obligation to treat in confidence all communications from the patient or the client which are necessary to enable the member of the profession to deal with or treat the particular case. These are called, in the law, privileged communications. The reason for the obligation is known to all members of both professions. It is, of course, imposed solely in the public interest and to enable the better treatment of medical cases and the more certain assurance that justice will ultimately be done.

The development of medical science and the great changes which have occurred within recent years in the making of medical records and the use of hospitals as a part of medical treatment have resulted in substantial disregard of the patient's right to have his necessary communications kept scrupulously privileged.

There is the problem of the extent to which the privilege extends to hospital records. The position of the interne and the nurse in respect of these communications may be doubtful unless it can be said that they are at all times the representatives, the *alter ego*, of the doctor himself. Even then this does not cover all situations.

In the public interest the medical profession must concern itself at once with the protection of the privileged communications of patients. Doctors must themselves be more discreet and circumspect. They must either refrain entirely from communicating such disclosures to their representatives or must find some means of controlling these representatives so as to prevent disclosure thereof by them. Since hospital records are at least in an uncertain zone and are sometimes brought into court, practically as a public record, the profession must give consideration to the extent to which privileged matters may appropriately be entered upon those records. I have had clients tell me that because confidential and privileged matters communicated to doctors apparently become public property very speedily and very readily, they have felt compelled to go to a remote city for medical and surgical attention. Whether or not this be an exaggeration, it is not in the public interest that such a condition be allowed either to grow up to any extent or to continue.

Perhaps the most delicate of all of these subjects is the malpractice case. I have heard doctors say that at least 95 per cent of these cases are "frame-ups." I know very well the attitude of the members of the medical profession toward this type of action. I can sympathize wholeheartedly with that attitude. You need not tell me the reprehensible part that all too many lawyers have had in these cases. Here again is a problem concerning both professions. The legal profession must do what it can to prevent lawyers from seeking out, "building up," or exaggerating cases of this nature against doctors. But when a meritorious malpractice case exists, the plaintiff is entitled to the testimony necessary to the presentation of his case conformable to the processes of justice. The abuse which exists today may be more imaginary than real. I hope it is; but I am constrained to say that, rightly or wrongly, there prevails, both in the legal profession and in the minds of the public generally, the belief that one doctor will not testify in a malpractice case against another, regardless of the facts. If this be true, and I know it is true to some extent, there has been created a condition which the legal profession and the public must take prompt means to correct. However unjustly individual doctors may be treated when made defendants in malpractice cases, the answer is not a concerted effort on the part of the medical profession to suppress evidence and to interfere with and obstruct the administration of justice. Nor, in the public interest, can it be the province of a committee of the medical profession to review and pass upon such cases and determine whether they "should be settled" or tried. Together with the feeling to which I have already adverted, is the further belief that even in meritorious malpractice cases the medical profession has combined and conspired and united to force settlements on its own terms with the express or implied threat that unless such settlement is made no doctor will testify in favor of the injured person.

From what I have said it is apparent that there is much for each profession to do within its own ranks and much for both professions to do working together, coördinating their efforts and coöperating for the incidental benefit of each and both professions but with the primary objective of serving the public.

Abuses, such as I have referred to, do exist. They do not exist to anything like the extent believed by the public. The danger is not lessened in any way by the fact that the public believes it has been injured to a degree which has been greatly exaggerated. As I said at the outset, the excuse for our existence as professions is the public belief that it is necessary for us to exist in the manner in which we now exist in order that the public interest be thereby better served. Just as soon as we fail to accomplish the purpose and objective set for us by the public, or, what is more important, just as soon as the public thinks and believes either warrantably or not that either profession is not attaining the goal prescribed for it, there will be further attacks such as those to which each profession is now being subjected and these attacks, unless steps are taken to correct the public impression causing them, will result in measures which will seriously restrict and limit each profession.

I can not be too emphatic in saying that each profession must see to it that its individual members place the public welfare and the public interest above personal individual advantage and gain. I am not speaking idealistically. I am stating blunt facts. The public will not be idealistic about the matter. It will demand that the individuals making up each profession so conduct themselves as to serve the public interest and, if they do not, they will probably ruthlessly, recklessly, and perhaps unwisely, sweep the boards clear of everything characteristic of our present day professions and substitute something in their place which will not at all be to our liking.

HERMAN M. JOHNSON*

Past and Present Medical Problems

THE HONORABLE ELMER A. BENSON

Governor of the State of Minnesota

Saint Paul, Minnesota

Introduction

J. M. HAYES, M.D., President, Minnesota State Medical Association: Members of the State Medical Association, honored guests, ladies and gentlemen.

We are assembled here in this large dining room of the Hotel Duluth at the largest luncheon meeting in the history of the organization to do honor to the name of our departed friend and servant, Dr. Herman M. Johnson.

To me one of the most important duties of any organization is the commemoration of the names of those who were the most important factors in the success of that organization.

No man ever made greater personal sacrifices for any organization than did Doctor Johnson for this one.

Not only did he make great personal sacrifices, but no man ever had a keener, clearer and more plausible insight into future medical policy than did this same Doctor Johnson.

One of the most remarkable traits of this man in all his work was that no one could ever, justly, accuse him of promoting any selfish interests. Everything he did was in the interest of the public and the profession.

By doing honor to such a man we are doing honor to the association, and to the profession. Honoring such men should inspire younger men, at least to some degree, to attempt to follow in his footsteps.

Those who did not have the good fortune to be brought into close contact with Herman or closely associated with him in his work, will never realize or appreciate the value of his work to this association.

Fortunately, his Honor, the Governor, was a friend of Dr. Herman Johnson and quite closely associated with him in his work for many years. This association, I believe, has been a benefit to the medical profession. This association, I believe, at least to some degree, has taught the governor that the practice of medicine cannot, in justice to all, be made a political football. This profession knows no political bounds.

I am pleased to say that my experience has taught me that the Governor knows and recognizes the fact that the practice of medicine must be controlled and administered by the practicing physician.

It is my pleasure to present, now, his Honor, the Governor, who will give the first memorial lecture in honor of our departed friend and servant, Dr. Herman M. Johnson.

His Honor, the Governor of Minnesota.

Address

THIS gathering today is a memorial to the late Dr. Herman M. Johnson, of Dawson, Minnesota. Two years ago, his sudden and unexpected death brought forth, from people throughout our state and nation, expressions of regret at his passing and praise for his work and memory.

One of his life-long friends, former Governor and Congressman Theodore Christianson, paid him a personal tribute from which I quote the following:

"He was the very soul of honor. . . . He was direct, outspoken, sincere. If he ever lacked in tact, it was because he was so honest that he preferred to tell the truth even when it hurt, rather than to keep silent and have his own conscience accuse him of insincerity.

"He had keen perception, and an analytical mind. The ability to note symptoms and diagnose causes, to trace effects to their source, which made his professional career notable . . . he carried into fields outside that of medicine. Ofttimes I have been with him when, as with a surgeon's skill, he dissected the social body and probed for the causes of its ailments. When so engaged, he showed that mingling of courage and caution that characterizes the true scientist. . . ."

In this tribute by Theodore Christianson, I concur with all my heart; for, like many of you who are here today, I had the good fortune to know Doctor Johnson personally.

Soon after Doctor Johnson's death, the House of Delegates of the Minnesota State Medical Association, adopted a resolution declaring their grateful remembrance of his aid to their organization and their profession. "We can but hope," they said, "that the memory of him which is ours, and his spirit which abides, will carry us all on to higher and greater achievements."

In that spirit, his friends created a trust fund to perpetuate his work and memory. One means of doing so will be these annual Herman M. Johnson Memorial Lectures, of which my address today is the first.

I think it is extremely important to bear in mind that when we commemorate significant

*First address given under the Herman M. Johnson Lectureship at the annual meeting of the Minnesota State Medical Association, Duluth, Minnesota, July 1, 1938.

work and noble men of the past, we do not have our eyes only upon the past; we have them also upon the present and the future.

A famous British scholar and scientist once pointed out that the present is, after all, merely the shifting point at which the past and future meet. We can have no quarrel with either the past or the future, he said. "There can be no world without traditions; neither can there be any life without movement. . . . There is never a moment when the new dawn is not breaking over the earth, and never a moment when the sunset ceases to die. It is well to greet serenely even the first glimmer of the dawn when we see it, not hastening towards it with undue speed, nor leaving the sunset without gratitude for the dying light that once was dawn."

In that spirit, we seek to perpetuate the memory and work of the late Dr. Herman M. Johnson. We do not want to forget his achievements; we want to look back upon them, and remember them with gratitude. At the same time, we do not wish to rest merely in the memory of such achievements; rather, we seek to take from them fresh inspiration to press forward to meet the challenging new problems of the future into which we are now entering. We seek to make the present not merely the twilight of a fortunate past, but also the dawn of a hopeful future.

Notable Achievements

In that spirit, we turn our eyes backward today for a few moments, to examine the notable and exceptional achievements of Dr. Herman Johnson.

Part of Doctor Johnson's distinction is the realism with which he adjusted himself to the special conditions of the period in which he lived.

He was born in the eighteen seventies. Up until then, changes in our economic and social conditions had taken place so slowly, that one could reasonably assume a man's children would live under conditions about like those under which he himself had lived. Since the eighteen seventies, however, owing largely to discovery and invention, change has taken place so rapidly that the very face of society has altered from one generation to the next.

Doctor Johnson began life in a pioneer community in Ottertail county, into which his parents had traveled in ox wagons from Wisconsin, about the time of the Civil War. As a child, he heard from the lips of his father many interesting stories of the first settlers in that region. When he himself began to practice medicine in western Minnesota, in the opening years of the twentieth century, rural calls were made with a horse and buggy. Between then, and the year when he died, nineteen thirty-five, there occurred sweeping changes in human knowledge, in the organization of human society, and in the problems confronting members of the medical profession.

Dr. Hugh Cabot, of the Mayo Clinic in Rochester, is authority for the statement that during the past forty years the development of scientific knowledge has given us more new knowledge, some of which is applicable to the treatment of disease, than the whole previous period of recorded history put together. The accumulation of scientific fact in that period, he declares, is so extensive as to stagger the imagination. As a result, during the past thirty-five or forty years, adjustments between professional activities, such as the practice of medicine, and current social and economic conditions have had to be made with a frequency and constancy which have challenged the caliber of men in the professions.

Doctor Johnson met that challenge. The record shows that he kept constantly abreast of the rapidly developing needs and opportunities of the medical profession during his lifetime.

Thus, one of the needs of Minnesota was a well organized and effective state-wide association of physicians and surgeons. Only by means of such an organization could the medical men of this state direct their influence fully toward developing programs of public health and promoting high professional standards in a highly complex society which was daily changing and becoming more complex.

Formerly, the Minnesota State Medical Association was only a loosely linked collection of county scientific societies. It exercised little influence in legislative councils. It assumed little responsibility for leadership in the protection of public health. Today, however, this association is generally spoken of by men in the medical profession as one of the best organized and most efficient medical societies in the United States. A great deal of the credit for this achievement belongs to the wisdom and ability

which Dr. Herman Johnson exercised in aiding that organization by his services, his contributions, and his counsel.

Outstanding Service

When the state medical association elected him president in nineteen twenty-six, they were indeed paying recognition to his medical scholarship and his skill as a physician and surgeon; but they were also honoring him for his faithful and important work, over a period of years, in behalf of the state medical association and the profession as a whole.

Doctor Johnson's outstanding service in that capacity was rendered as chairman of the Minnesota State Medical Association's committee on public policy and legislation.

In that position, he gave every effort to securing adequate appropriations for the equipment and maintenance of a first-class medical school at the University of Minnesota, which would meet the new needs for longer and more specialized training, and for wider and more extensive scientific research.

He gave every effort to securing adequate appropriations for our State Board of Health, whose record of achievement in public health programs is envied in many states of the union.

For the Public Welfare

He took part in achieving Minnesota's outstanding piece of medical legislation, namely, the Basic Science Law, enacted in nineteen twenty-seven, and generally regarded as a model of basic science legislation.

To Doctor Johnson, perhaps more than to any other person, should go credit for making the Minnesota State Board of Medical Examiners a self-supporting body.

Furthermore, he worked to have the Medical Act amended, so that when vacancies occurred on this Board, recommendations for filling them should be made to the governor by the Council of the Minnesota State Medical Association. He believed that recommendations made by organized medicine would be helpful to the governor in making these appointments. Here today, I have the privilege and honor of publicly acknowledging that we have kept faith with Doctor Johnson in this matter. The two most recent appointments to the State Board of Medical Examiners have been made in accordance with the recommendations of the Council of the State Medical Association, as he hoped they would be.

One of Doctor Johnson's most important and humane contributions to the people of this state was the coöperation he rendered, in nineteen thirty-four, when the state emergency relief administration was being set up. He spent many days conferring with relief administrators, and helping to organize the work, in an effort to insure that those who were unfortunate enough to be out of work and in need of relief would be able to secure the services of their own family physician when needed.

These achievements which I have been enumerating, are only a fragment of the long role of Doctor Johnson's public services.

They were prompted by his recognition of the fact that the medical profession, like all other human occupations, must constantly readjust its practices and organization to meet the intricate needs of today's complex conditions of life.

They were prompted by the social idealism which causes men like Doctor Johnson to labor wholeheartedly and with unfailing optimism for the achievement of the highest excellence in human skill, in human character, and in the organization of human activities.

They were prompted by the true spirit of liberalism, which, possessed of abundant and realistic knowledge of the facts and a sense of social perspective, seeks to find creative, rather than repressive, measures for liberating men from the diseases and scourges which afflict them.

How the work and memory of this man may best be perpetuated lies, after all, in the hands of the medical profession of this state. Speaking as a layman, I venture to suggest that the best way to do so is to apply his combination of social vision and a practical spirit to the facts and issues of the present.

From that point of view, let me try to outline for you what seems to me the next great field for organized medicine to tackle in the spirit of the late Dr. Herman Johnson.

Progress in Public Health

The province of caring for human health covers two fields. One field, the field of general medicine, is concerned with restoring sick persons to health. The other field, the field of preventive medicine, is concerned with maintaining healthy conditions of living in our highly

complex and artificial mode of living and working.

In this second field, the field of public health programs, the medical profession has been more than abreast of public demand. True, our programs of public health have not been entirely satisfactory; they have been marked by confusion, overlapping, and inadequacy—especially in the rural sections. This condition, however, is chiefly the result of inadequate legislation and lack of public understanding. Scientists and physicians have done their part in seeking to rouse people to the importance of adequate legislation and appropriations to carry on programs to protect the public's health by promoting sanitary living conditions, by checking the interstate transmission of disease, by preventing the pollution of public streams which flow from one community to another, by officially inspecting foods and drugs, by warding off occupational diseases and the effects of overwork in today's factories and mines, and by the collection of uniform vital statistics. In all these matters, medical knowledge has usually preceded that of the laity.

As a result, the field of preventive medicine and public health is beginning to be conquered. There already exist in the federal government, for example, at least two dozen agencies concerning themselves with the problems of public health, such as the United States Public Health Service, the Children's Bureau, the Women's Bureau, and the Bureau of Chemistry.

The Next Great Field

In the other and older field of medicine, however—in the field of general medicine, concerned with restoring sick persons to health, the medical profession is falling behind the public demands of the moment. As everybody knows, this is not because of any lack of scientific knowledge, skill, or devotion to the highest professional standards. It is owing to the fact that the present organization of our medical services does not provide for the widest possible application of those services to all our people.

In the year that Doctor Johnson died, in 1935, the President's Committee on Economic Security reported that "nearly one-half of the individuals in the lowest income group receive no professional medical or dental attention of any kind." The Committee also reported that millions of American families live in dread of sickness because when illness strikes one of their members they are compelled to sacrifice other essentials of decent living, or go without needed medical care, or depend upon the charity services of doctors and hospitals. Such a condition leaves large sections of our population without adequate medical service, and at the same time fails to provide adequate employment for large numbers of potential physicians and nurses.

Now, you and I both agree that it would be wrong to lay the blame for this state of affairs upon the medical profession. If blame belongs anywhere, it is upon the economic arrangements of our society. The important thing, however, is not to blame anybody, but rather to recognize that the problem exists, and then to seek methods of coping with it.

How will the problem be solved? I, as a layman, can scarcely venture an answer to such a question. The answer must come from the medical profession itself. *I may say, however, that I do not believe our people favor a government-dominated medicine.* On the one hand, they hold the medical profession in great esteem, owing to its traditions of learning, skill, and personal integrity; on the other hand, they lack faith in the arbitrary centralization of power which they fear would come from government-dominated medicine. Furthermore, the medical profession itself would not tolerate such an approach to the question.

Medicine's Problem

Nevertheless, we must recognize that the problem of providing all our people with some semblance of equality of opportunity for adequate medical service is one of the insistent problems of our time. This first memorial lecture, in commemoration of Dr. Herman Johnson, is the most fitting occasion possible on which to draw clear-cut attention to this problem, whose solution is the next step in the advance of organized medicine.

We laymen have confidence that the profession which produces and pays tribute to men of the caliber of Doctor Johnson, has also in its ranks the social vision combined with the practical capacity to grapple with this problem, and work out a solution which will neither mar the integrity of the profession itself, nor leave the medical needs of our population unmet.

Surely the time is not far distant when our people may expect government to aid them in

guaranteeing minimum standards of economic well-being, including medical attention of the kind they receive from the physician and surgeon whom they know and confide in. The people of this state would, I believe, be willing to consider favorably legislation designed toward this end, provided it came from the state medical association and represented their best judgment and matured experience. Such legislation would be one of the ways of keeping alive the memory and work of the late Dr. Herman Johnson. It would be evidence that his spirit abides, and is carrying us all on to higher and greater achievements. It would proclaim to all the world that we in Minnesota do not only rest in the twilight of a fortunate past, but also move forward serenely and without undue haste to greet the dawn of a more hopeful future.

FRACTURES—GENERAL PRINCIPLES*

CLARENCE JACOBSON, M.D.
Chisholm, Minnesota

THE treatment of fractures has its origin in the Neolithic age. Specimens have been discovered in sufficient quantities to justify statistical statements. Karl Jaeger found 53.8 per cent of good unions as against 46.2 per cent bad unions in prehistoric fractures, indeed a credit to Neolithic intelligence. Immobilization was practiced in the 4th Dynasty, about 2500 B. C. by means of well padded palm branch splints. Hippocrates, 460-377 B.C., describes mechanical extension for fractures of the thigh and leg. He advised treating fractures of the jaw by binding the teeth together with gold or linen thread. Fundamental principles adhered to by the ancients are still in use and to a great extent form the basis of modern treatment.

The first consideration in the treatment of fractures is to save the patient's life. Treatment begins the moment he is touched at the scene of accident and not after the arrival at the hospital. Preparatory to transportation, the patient is kept warm, morphine administered if necessary to control pain. The application of the Thomas Splint in fracture of the long bones is often a life saving measure and should be done before the patient is lifted from the ground. If possible, traction thus maintained should be fixed throughout the remainder of the treatment. This procedure combats shock, prevents further serious injury at the site of fracture, and adds materially to the comfort of the patient during transportation. Many hospitals make it compulsory to transport acute fractures of the long bones with some form of traction. The use of the Thomas Splint during the World War reduced the mortality from 80 per cent in 1916 to 15.6 per cent in 1917 in compound fractures of the femur alone.

Patients with fractures of the spine should be gently rolled on to a blanket face down and lifted by means of the blanket onto the stretcher, and kept lying on the abdomen during transportation. Cervicle spine fractures are best transported with some form of extension. In case of a suspected skull fracture the patient should receive no morphine and should be transported to the nearest hospital. If found in a home where favorable surroundings exist, transportation may well be postponed, a capable nurse secured to record the pulse, respiration, temperature and blood pressure. Emergency operative treatment in acute skull fractures should be limited to compound fractures, those showing marked depression of the skull, cases of extradural hemorrhage, and those exhibiting constant recurring convulsions.

Life is threatened in elderly patients who are suddenly compelled to lie in bed. Pneumonia and bed sores are often immediate complications. In the absence of shock it is imperative to free these people from pain and compel them to sit up. Recent fixation treatment with the Smith Peterson nail and other similar metal devices for fracture of the femoral neck have proven a boon to elderly people in whom these fractures so frequently occur.

Having assured ourselves that life is not in danger, our attention is centered on saving the injured part and to return in the shortest time the fullest capacity of function. Careful exam-

*Read before the Annual Meeting of the Minnesota State Medical Association, Duluth, Minnesota, June 30, 1938.

ination of the injured limb is important, taking note of contusions and skin abrasions, injuries to tendons, muscles, nerves and vessels. Musculospiral paralysis is often missed in fractures of the humerus on first examination because of the attention being centered on the fracture. Amputation other than for the purpose of saving life should be based upon the extent of gross injury to the tissues and the question of adequate blood supply to the distal part. A more conscientious appraisal of these aspects has led to fewer amputations in late years.

Physiological principles are concerned with the healing of bone as well as the restoration of the injured limb to normal function. Immediately following a break, an orderly process of repair is begun. An interlacing mesh of fibrin derived from the blood clot, lymph and inflammatory exudate begins to bind the bone and adjacent lacerated tissues together. Within a few hours fibroblasts appear in the fibrin clot and granulation tissue formation begins. Cells from the endosteum, marrow, reticulum and periosteum enter into this formation as well. Organization takes place within forty-two to ninety-six hours. The manner in which calcium is deposited is not understood other than it makes its appearance as early as seventy-two hours after fracture, being deposited in the granulating tissue. This constitutes what is known as early callus formation. Denser deposits gradually appear, the concentration becoming sufficient to cause hard bone formation. Subsequent use of the limb causes the return of the normal architecture of the bone. A year or more is required to complete the process.

Interference with this normal process results in non-union. Among the common causes are poor apposition of fragments, early massage and passive motion, interposition of tissue even though it be periosteum, infection, extensive damage to soft parts at the site of the break, and, for purpose of emphasis, manipulation of the slow healing fracture. Failure to note callus formation on the x-ray plate lead many to unnecessary manipulation. It should be remembered that firm union often takes place without visible evidence of callus on the x-ray plate. Non-union can often be prognosticated on a history of violent injury such as having a limb caught in revolving machinery carrying the body with it, or in an auto accident where the car has turned several times with the occupant within. In these types the force producing the fracture has continued to act over a period of time. Cubbins states, "It is the continuation of force that has caused the interposition of tissue, that injures and destroys the periosteum, that causes its twisting and being torn to bits, as well as injury to the blood supply of the bones and adjacent tissues."

Principles governing the treatment of fractures are concerned with the best means of obtaining union in good functional position. Proper reduction is first to be desired. Perfect anatomical reduction should be attempted, but not at the expense of destroying possibilities of good function. Boehler, known for his exacting procedures, often allows up to one centimeter overlapping of fragments providing the alignment is correct. Actual lengthening of the lower limb has been noted by Magnusson and others after two years in femur fractures in children where no shortening was demonstrated at the time of discharge. The methods of reduction are many. Traction, manipulation and open operation are fundamentally the only three. Boehler states that every fracture should be reduced by traction and counter-traction. Manipulation, when used, should be reduced to the fewest number of movements and not over longer periods than absolutely necessary. Delayed healing and nonunion may be attributed to this procedure. There is much wasteful controversy over the merits of the open and the closed method of treating acute fractures. Whichever method gives the best results in function in the individual surgeon's experience should be used. All are agreed that there are certain fractures where open operation is necessary for maximum restoration of function. These compose the fractures involving joints where fragments are in poor apposition, some of the fractures of the mid forearm involving both bones, fractures of the patella and olecranon process, in fractures where there is known to be interposition of tissue between the fragments and in instances where fragments are widely separated. The optimum results are obtained in open reduction when the cases are selected and operated upon immediately. Henderson advises not to limit its use to cases in which the closed method has failed. Often in cases seen late where the closed method would have been satisfactory, he chooses to use the

open method. Skeletal traction by the use of Kirschner wire serves as an excellent method in obtaining proper reduction and in maintaining adequate retention. The Steinmann pin is likewise used. Some claim bone infection is more apt to take place when the latter is used. Boehler, however, blames infection upon the rotation of the pin within the bone, and has devised bearings on the tractors attached to the pin preventing it from rotating, and has had no further trouble. Maintaining reduction by means of a Steinmann pin incorporated within a cast as advocated by Roger Anderson has produced excellent results. Experience in this method and maintenance of aseptic surgical technic is imperative, not only in this method but in all methods involving entrance into bone with foreign material.

The means of retaining a properly reduced fracture is often the most difficult problem in fracture management. Fractures are maintained in their abnormal positions by muscle pull, gravity playing a part as well. When properly reduced anatomically and placed in a neutral position, the muscles of the limb resume a balanced pull and render a comparatively easy retention with the ends of the bones locked. Boehler has gone to great length in explaining the various neutral positions which must be maintained in proper retention. Thus, in fractures of the upper end of the humerus, the arm must be abducted 90 degrees, externally rotated 90 degrees and brought anteriorly 30 to 40 degrees. Correct alignment and anatomical apposition is thus attained. In fractures of the neck of the femur, we find that abduction with internal rotation produces the neutral position. In supracondylar fractures of the humerus, assuming the flexion and varus (adduction) position often interferes with the circulation and innervation to the forearm. Early recognition of vessel injury must be noted to prevent the dreaded Volkmann's ischemic paralysis. This was formerly thought to be due to tight dressings alone. We now know that blood from a severed or torn vessel has infiltrated the fascial planes which, not being elastic, causes enough tension to produce ischemia. The blood must be evacuated immediately. The radial pulse must return before the danger is passed. Boehler is not in accord with the usual practice of reducing and maintaining this fracture with the forearm in supination, for the simple reason that in so doing the pronator muscles, which are also flexors, being on the stretch, are in a state of spasm and tend to maintain adduction of the distal fragment causing impingement on the radial nerve. This is corrected by pronating the forearm, thereby bringing it into a relaxed position correcting the varus or adduction deformity. Being also flexors of the elbow joint, relaxation of the pronators brings about reduction of the flexion deformity. Retention is maintained by means of traction on an abduction splint in adults, either by plaster cast, aluminum or wire airoplane splints. The Jones sling and adhesive may suffice in children following satisfactory reduction. The same principle of neutral position with balance muscle pull holds for all fractures of long bones.

Operative retention by means of metal bone plates and screws may be necessary. The Lane technic must be strictly adhered to. Venable has shown that the metals commonly used are not suitable. When two different metals were used in plating a fracture, the difference in potential of these metals thus placed in the tissue acted like plates in a storage battery causing electrolysis to take place. Thus the screws were seen to loosen with consequent loss of retention. Certain alloys acted similarly. The best metal was found to be an alloy composed of cobalt, tungsten and chromium, called vitalium, which resists both electrolytic and chemical action of the body fluids.

Immobilization of the fracture is necessary until firm union takes place. This varies in individuals, and to a great extent in the type and location of the fracture. Firm union is best determined by the x-ray, although, as previously stated, union can take place without visible callus formation. The rule is, nevertheless, not to permit weight bearing or lifting without mature callus formation. Tenderness over the site of fracture means immature callus formation, and is, therefore, a warning to withhold use of the limb. Early removal of the cast for passive motion and massage is to be condemned. Non-union as well as myositis ossificans has resulted in these cases. Active motion is safer and is to be encouraged.

Restoration by functional treatment as advocated by Boehler is a distinct contribution to the industrial surgeon. He defines functional treatment as "the complete uninterrupted fixation of

the fragments in good position with the simultaneous active movements of all the joints, or as many as possible, and with the avoidance of pain." In short, this means immobilization with a cast placed upon the unshaven skin of an extremity and immediate use of the limb. A metal heel is incorporated in the cast in fractures of the lower extremities, and the patient made to walk as soon as the plaster-of-Paris is hardened. Circulation is thus made more active, atrophy of bone is avoided and the joints return to full function in a much shorter time. Fixation can thus be prolonged with safety. Compression fractures of dorsal and lumbar vertebræ are immediately reduced, guided by x-ray films and retained in a body cast, pressure being applied to three points, the upper portion of the sternum, pubic bone and at the site of fracture on the spine, thus maintaining the spine in lordosis. Patients without paralysis are encouraged to be up in twenty-four to thirty-six hours and are given weights to carry on their heads and such exercises as are necessary to keep up good muscle tone. Caution should be undoubtedly exercised in immediately adopting all these methods. We have had occasion to use this form of treatment in a sufficient number of cases to justify our continuing doing so. Experience gradually acquired will undoubtedly reveal the fact that the principle is physiologically sound, and that the future will see wider adoption of this method of treatment.

Needless to say, the keeping of accurate records and progress notes is as important in proper fracture management as in any other field in medicine. Many an unjust lawsuit has been won because of the poor record submitted at court. Litigation must be kept in mind in every fracture case. Failure to produce x-ray films before and after reduction has led to the same sad end. Plates taken in anterior, posterior and lateral planes suffice for the majority of cases. Plates at various angles may be necessary before ruling out fracture in instances where it is strongly suspected. Follow-up plates are necessary and should be taken every eight days until firm union takes place.

The general principles applicable to the proper management of fractures have been briefly alluded to. The best results will be obtained if whatever method is being employed proves to be physiologically sound. Perfect anatomical result should not be at the expense of optimum functional result. Most of the estimated 1,500,000 fractures occurring yearly in the United States are first seen by the practitioner and general surgeon. Smaller communities are being better equipped to care for these emergencies. We find that adequate consultation in complicated cases is of great value, not only for self protection, but for the welfare of the patient and his continued coöperation through a trying period of convalescence.

Summary

1. Some of the fundamental principles of present-day fracture treatment were used in ancient times.

2. The first consideration in dealing with fractures is the saving of life. Treatment begins when the patient is first seen at the place of accident. Proper first aid is of paramount importance as a life saving measure.

3. The use of the Thomas splint affords the necessary traction for fractures of the long bones and should be used in the transportation of patients with fractures of the long bones.

4. Interference with the normal process of healing by unnecessary manipulation and by early massage and passive motion is the cause of non-union. Cases of myositis ossificans have been reported by Boehler as a result of these measures.

5. Reduction is best produced by traction against counter-traction.

6. Retention in the neutral position of balanced muscle pull is necessary.

7. Longer periods of immobilization are to be desired for better bony union. Keeping the fracture immobilized and at the same time keeping the muscles and uninvolved joints active will prevent bone atrophy, and shorten the period of disability.

8. Adequate fracture and follow-up records, as well as proper x-ray plates during the healing period, are important aids to both patient and surgeon.

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Discussion

DR. E. E. CHRISTENSEN, Winona: Dr. Jacobson has presented a very comprehensive review of the general principles of fractures.

His statements relative to the values of the open and closed method, I believe, are very fair. The open method should not be reserved for only those cases in which reduction has been impossible after repeated manipulations, but rather a method of choice when the surgeon recognizes the fact that he has to deal with a particularly difficult reduction and when the proper facilities are at hand. The failure to recognize these cases often leads to repeated manipulations and consequent permanent damage to the tissues.

Skeletal traction when properly applied has been of untold value in the treatment of fractures. However, these cases must of necessity be watched very closely and checked repeatedly by x-ray studies to avoid an over-correction or the pulling apart of the bony fragments with a resulting delayed or non-union. I believe this is more apt to be true when the Roger Anderson method of fixed skeletal traction is used in fractures of the neck of the femur, or in fractures of the long bones where there has been fixation by pins according to the method of Boehler. Of course in the hands of these men the results obtained encourage the contention that their methods are the ones of choice. However, the average practitioner, with a limitation of experience and perhaps limited facilities, should proceed, I believe, along more conservative lines.

I would like to bring to mind the so-called compensatory fracture, the majority of which occur in the leg due to the powerful action of the leg muscles. Here we encounter a fracture of the lower end of the tibia and our attention is centered on this one area. Unless we keep in mind the possibility of a fracture of the upper third of the fibula we may often overlook this point. The same holds true of the bones of the forearm but to a lesser degree, due to the free rotation of the latter. This type of fracture was brought to my mind very forcibly about four months ago when I completely missed the fractured upper fibula. It was only because of repeated complaints on the part of the patient that I had further x-ray studies made on the third day, and you can imagine my embarrassment when the second fracture was found. It is true that in most fractures of this type the end-result would not be appreciably, if at all, effected, if the second fracture were missed, but it is because of the medicolegal angle that we must keep this in mind.

My experience in immobilizing fractures with a cast directly upon the unshaven skin has not been satisfactory. I have noted a much greater tendency toward development of areas of pressure necrosis with this method than when using sufficient padding, particularly over the bony protuberances.

In the past four years we, in our group, have treated with very good results a series of thirty-nine compression fractures of the spine. Following reduction and the application of a cast, those in which there was no evidence of paralysis were allowed to be up as soon as they were free of pain and abdominal distention. This usually took between one and three weeks, depending upon the severity of the fracture. Most authorities are agreed that this type of fracture should be in a cast or brace and in the recumbent position for a period of from six to eight weeks. Dr. Jacobson has adopted the Boehler method, that of making this type of patient ambulatory in from twenty-four to thirty-six hours. This is even a greater departure from the time honored methods than what we have been using. If this treatment is correct, it will revolutionize the treatment of fractures of the spine in this country.

I thoroughly agree with Dr. Jacobson that follow-up records and frequent x-ray studies are necessary during convalescence for it is the one means that the surgeon has of knowing just what is going on. Failure to do this may result in a disability that affects the patient's earning capacity, which, in turn, assumes an economic and a medicolegal importance.

RECOGNITION AND TREATMENT OF REFRACTIVE ERRORS IN CHILDREN*

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ALL animals that move on the land, or in the sea, or air, have eyes to guide their movements. But these eyes differ greatly, to meet the special requirements of the animal. The eyes of a puppy are closed after birth; perhaps to keep him from running away from his source of food until he has learned to stay with it. The eyes of the colt are open from the start. With sight, his long legs can save him from wolves, or other enemies. The eyes of the infant open at once, to begin the long training in their use that they must have before they will be ready for the tasks of school and labor.

Human eyes differ from the eyes of the lower animals. Most lower animals need to see clearly at a distance, to keep away from their enemies, and to know where to seek their food. Men, too, need to see clearly at a distance; but they also need to see things held close to their eyes. They can see far away, but they also have a focussing muscle, that enables them to see small objects held very close to the eyes. Nearly all babies' eyes are hyperopic (far-sighted), and the average amount of hyperopia would unfit the eyes for use in school work.

Young children, with short arms, use their eyes for looking at small things held close to

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their eyes. By this they get less and less far-sighted. At school age, six years, the average amount of hyperopia is not much over 2D.; and a few eyes have grown near-sighted. If the child strains its eyes, by holding things too close to them, they will become more and more near-sighted. They thus become subject to the dangers that may bring blindness from atrophy of the choroid, separation of the retina, or cataract. The wearing of glasses that enable the scholar to read print farther from the eyes, is the one important thing to prevent increase of myopia, and its consequences.

Astigmatism is a defect in the refraction of the eye, that prevents the light, which should be focussed to one point in the eye, from being so focussed. It causes the blurring of images formed on the retina, and causes straining of the eye to get the best image it can. It affects the seeing at all distances, and at all times. It usually continues throughout life but is liable to change from time to time. These anomalies or errors of refraction are so common and so serious in their effects during school life, that their early recognition and correction is very important.

Human vision is different from that of the lower animals. The human eye has the same powers of refracting light and forming images on the retina, the wide field of vision, and power of adaptation to light or darkness. But it also has greater power in detecting separate points of light, coming to it from different points of viewed objects that are close together. The cerebral coördinations of vision in man are far wider and more important than those of the lower mammals. The dog knows his master and recognizes other animals by his sense of smell. Man recognizes and discriminates by sight. His memories of persons and objects, animate and inanimate, are visual memories. In all our memories and coördinated thought, visual impressions predominate. Only what we learn by hearing may be compared with what we learn through vision.

The vision of the human eye is different because of the macula developed in the retina. The general retina is one of the first parts to become recognizable in the fetus, and it is well developed at birth. The macula cannot be recognized until the middle of fetal life, and continues to develop for months after birth. It may not reach its full functional capacity until the child is six or eight years old. Macular vision enables us to distinguish letters or small figures and to follow the mechanical trades that depend on "good vision." The education secured at school through use of books, exact drawing, fine needlework, and all the more accurate handicrafts, depend on macular vision. This is the kind of vision that makes possible human usefulness, successful living, and rational pleasure. Good macular vision is what is generally meant by "good vision." Our common tests of vision are tests of vision at the macula. Visual acuity is the visual acuity of the macula. In all normal eyes the visual acuteness rapidly decreases in the retinal field away from the macula. The vision, as usually tested and recorded, depends on the sensitiveness and accurate focussing of the light falling on the macula. This determines the effectiveness of the eyes in all kinds of school work. No scholar who has an uncorrected defect in vision should be expected to compete with others whose vision is perfect. Justice in the school room demands equal vision for the performance of visual tasks. So far as is possible, this should be brought about. Progress in learning is the purpose of schools, and it depends on seeing and hearing.

The school curriculum should provide first for the building of a strong, efficient body. The value and efficiency of our schools would be greatly increased, if the first two years of school life were devoted strictly to the building of bodily health. This could be effected by supervised playground exercises, directed to developing the power and control of the body. During this health education, the defects of sight could be detected, and refractive and motor defects of sight could be corrected before the most important employment of vision had to be entered upon.

How Are Refractive Errors Known?

Many children have been puzzled by defective vision, but have not understood what was the matter. Often, parents have thought that the child was simply inattentive, or stupid, or was not trying to see. But there is no excuse, except ignorance, or indifference, for not knowing how well, or how poorly, a child can see. Many charts have been devised for testing the vision of children and illiterates. The easiest and most efficient is the incomplete square, proposed by Snellen, when he found that his test letters were

not a good test for people who did not know their letters. Such a test may be turned in either of four directions, and the child asked or told to point in which direction the opening is turned. With this, a dozen children may be tested together, and in less time than for the same number of adults to be tested with letters. If a child does not have standard, or par, vision, some error of refraction should be thought of, as the most common cause of poor sight.

In the presence of refraction errors, perfect sight may be possible but more difficult. Children in this class are slower to see than those with good sight; or they do not like to study, seem in poor health, tire easily; or they have some nervous symptoms, as headache, restlessness, or nausea, or vomiting, when they use their eyes much for reading. These symptoms may come from other causes, but in school children who are having difficulty in keeping up with their classes, refractive errors should be first considered. The same troubles may be brought on by other things, such as poor light for reading, impaired health by loss of sleep, poor diet, lack of outdoor exercises, excessive home duties; or chronic disease, as malaria or tuberculosis. But the excessive demand of school studies with eye strain is obviously the first thing to be thought of by school authorities, parents, school physicians, or nurses, when they recognize any such departure from health in school children.

Defects of vision are so important to school children that their presence should not be left to accidental discovery. They should be kept in mind and looked for in every child coming under the care of school authorities. Parents do not expect such defects in their own children and have very little knowledge of how children with ordinary sight may be entirely unable to meet the requirements of school tasks. The playground supervisor and the grade teacher have ideal opportunities for observing such defects.

The indications of defective vision, such as holding the book too close to the eyes, or quickly getting tired of reading and letting the attention wander to more distant objects, may need to be explained to teachers and parents. This, the properly trained school nurse, or school physician, or the principal should be prepared to do. The assumption that the understanding of such things will come by nature is on a level with the explanation that reading and writing come by nature. Provision should be made to teach children what is good health and how to have it. This is the most important subject that can be taught in schools.

The campaign for health may well begin with the better lighting of homes and school rooms. Light, by contracting the pupil, is a universal corrective for all refractive errors. Try the small pupils for yourself. Take a +4. D. lens from the trial set, or grandmother's spectacles, too strong to see clearly with across the room. See how much blurring results. Then take the pinhole disk from the trial case, or a pin hole in any thin card, and hold it in contact with the glass, and look through the pin hole across the room. A few seconds will convince you of the effect of a contracted pupil in correcting the blurring due to refractive errors of the eye. The real need of corrective glasses can only be known by measuring the ocular refraction, knowing what the eyes are expected to do, and carefully considering the symptoms and the general strength and nutrition of the child. The absurdity of turning over health problems and health maintenance to the advertising claimants of skill in measuring eyes who in general call themselves "optometrists," may be easily appreciated.

There is a general feeling that this subject of optics is complex and beyond the average physician. In the cities, where certain young men are looking forward to making ophthalmology their life work, the proper examination of the eyes of all school children can be easily provided. In the country there are physicians in general practice who have time to read and study the methods of examining eyes for congenital defects including those of refraction. Any young physician might use his spare time in this way while waiting for a full practice, and thus improve his own fortune and render a very important service to his community. The practical points of visual optics are not so abstruse as might be supposed from looking over the classical books on the subject. And a training in medical diagnosis is the best preparation for the recognition and measurement of the refractive errors and motor anomalies of the eye. Experts in salesmanship, radio and newspaper advertisers, and the manufacturers of instruments and lenses, have profited by confusing the general public as to visual defects and their correction. Any well trained

physician may quickly train himself to give optical corrections to school children or patients.

For detection of optical defects in school children, a few schools have every child's eyes examined by a school physician. Others have the vision tested by a school nurse. This discloses myopia and high astigmatism. But other defects, such as high degrees of hyperopia, causing eyestrain, headaches, lack of attention and dislike of reading, can be only suspected by a teacher from daily observation. The essential point is that some one who knows of the existence of such defects, should be on the lookout for evidence of their presence. The presence of refractive errors, or their absence, may be determined in each child only on examination by an oculist.

Good lighting and correction of refractive errors supplement each other, but one is not a substitute for the other. In every school room will be found pupils who need correction of their refractive errors; and in most school rooms are children with desks poorly lighted. An exact light-meter, or sight-meter, should be used in every school room, to test the light available for use on the desk of each child.

The treatment of the refractive errors of the eyes of children is a most important, forward-looking step in preventive medicine—the medicine of the future. It is a great duty of parents to children, of one generation to the next. It is a duty of the State which demands the education of the young, to make them better citizens. It is the duty of the medical profession, to maintain and live up to its claim of leadership, in providing for the health of all the people. The service rendered to the child will last longer, and do more for the general welfare than anything that can be done for older people. All the knowledge and skill of the oculist of today should be applied in this developing branch of preventive medicine.

MEDICAL CARE

A wave of publicity regarding medical care is going over the entire country at the present time. Magazine articles, editorials and special syndicate articles are to be found in almost every periodical one picks up. We offer the following, reproduced with thanks by special permission of the *Minneapolis Journal* and United Features Syndicate, holders of the copyright, from the pen of the well known writer, Mr. Westbrook Pegler:

"The problem of medical and surgical treatment for the masses is cluttered with undeserved pity for people who have convinced themselves they can't pay the doctor for easing their pains or saving their lives, but could do so if they tried.

"The doctors of this country give away more free goods off their shelves than the members of any other profession, including actors and musicians, who come next.

"They have their gyps and rotters, their publicity-crazy hams and ignoramuses, but they do more good for suffering humanity and in critical moments than the members of any other calling.

"Of course, it will be argued that they should do this because they are in a position to. That is their job. But the fact is, nevertheless, that they do give this service, and it is a further fact that society doesn't appreciate the good they do.

"People overemphasize their mistakes of judgment or negligence, forgetting that a doctor's mistake is more likely to have fatal, or, anyway, dreadful consequences than a mistake by a plumber, a grocer, or a journalist.

"If the work of the plumber springs a leak, if the grocer sends Snookies instead of Snackies, or if the reporter names W. C. Smith as corespondent in the divorce story when it should have been W. G. Smith, that means very little paint off anyone's fenders.

"But, let a doctor make a comparable mistake and there is all hell to pay, on top of the fact that maybe he stood to be swindled out of his pay—or most of it, anyway—even if he had done a bang-up job.

"There are many phases of the question, but I mean to stick to this one for today's lesson. I am thinking of those who think that a couple of hundred dollars is an outrageous price to pay for the removal of an appendix which has developed the menacing nature of a bomb in the patient's inwards.

"The surgeon gets the victim into a hospital as quickly as possible, gives him a jab of something to relax him and in a very short time is delving around in his giblets without 50 cents on the line to pay for laundering his smock.

"So the patient gets well, and when the bad news comes he forgets that feeling as of a litter of porcupines frisking about in his abdomen, forgets how scared he was and his alarm for the security of his dependent family, and calls the doctor a burglar.

"Why, he makes only $25 a week, and so, instead of paying the doctor a dollar a week, as he would pay for a radio or sewing machine, his policy is to skip it entirely.

"He forgets also that if the surgeon hadn't done his stuff promptly and well, specialized stuff that nobody but a surgeon could have done, his family would be on the town right now.

* * *

"If a patient can pay small amounts to a coöperative over a spell of years for treatment which he may need in the future, he can just as well pay a doctor a stated amount each week over a long term for treatment which he has already received.

"But, in too many cases he just won't, and the doctor is accused of bearing down on a man who can't afford to pay for the saving of his life but can manage somehow to come up with the price of many non-essentials.

"Many doctors nowadays serve patients in the public clinics who are able to pay reasonable professional rates for their treatment.

"There is more or less larceny in all the human race and this problem of medicine for the masses would be less difficult if those who can pay were prevented from appealing to public sympathy at the doctor's expense by mingling with the truly destitute."—Copyright, 1938. Reprinted from *Bulletin of the Hennepin County Medical Society*, August 25, 1938.

CASE REPORT

TRIPLET PREGNANCIES—TWO CASE REPORTS*

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TRIPLET pregnancies because of their rarity and because of the greater possibility of the development of complications for the mother should be regarded as definitely pathological.

Dr. J. C. Hirst in a recently published paper reports on a series of 48,357 viable pregnancies with delivery at the Philadelphia Lying-In Hospital, the University of Pennsylvania Hospital, and the Preston Retreat with an incidence of only four sets of triplets. Of these triplets, two sets survived. Complications present in one or more of these triplet pregnancies were unusual weight gain, hypertension, slow labor, "vague labor," puerperal endometritis, and abruptio placentæ between the second and third infants. The two cases I shall report are interesting in that both sets of triplets survived, both mothers exhibited hypertension and albuminuria (true toxemias of pregnancy), and in both cases the placenta separated between the births of the second and third babies, necessitating extraction of the third baby to save it from asphyxiation. Diagnosis of triplets was made in each case by x-ray study.

Case 1.—Mrs. M. R., a multipara, aged thirty-seven, gravida V, para IV, was seen at regular intervals during her pregnancy until December 7, 1929. At this time the patient was sent into the hospital for observation and study because of loss of 8.5 pounds in weight in one week, albuminuria 2 plus to 4 plus, excessive swelling of ankles, hypertension, and orthopnea of two weeks' duration. Patient's last menstrual period was on April 28, 1929, and her estimated date of confinement was February 5, 1930. The last menstrual period was slight in amount. Patient's past history was essentially negative. She had had four previous full term normal pregnancies and deliveries, labors averaging two hours or less.

General physical examination on admission to the hospital was essentially negative except for the fact that the patient appeared extremely emaciated, and that her blood pressure was 165/95. Blood pressure during her stay in the hospital varied between 192/106 during labor to 126/70 at the time of discharge. Eyeground examination was negative. Urine examination showed albumen varying from 0.4 to 3.5 grams per litre. Blood examination showed a hemoglobin of 77 per cent, 4,270,000 red cells, and 6,950 leukocytes. The Van Slyke estimation was 59 per cent. The blood urea was 7.7 milligrams, blood sugar .07, and creatinin 1.3 milligrams. X-ray taken on December 9, 1929 (Fig. 1) showed the presence of triplets with the head of one fetus in the fundus, the head of the second overlying the pelvic inlet, and the head of the third in the left upper quadrant. The size of the babies was approximately that of an eight months' gestation.

Labor began about 5 p. m. on December 25, 1929. Pains at first were quite weak but rapidly became stronger. Rectal examination at 5 p. m. showed a dilatation of 3 cm. and 50 per cent effacement with the head of the first fetus well below the spines. The membranes were intact and the fetal heart tones were good. The cervix dilated and effaced very rapidly with complete dilatation at about 6 p. m. The first baby was delivered in the OLA position at 6:40 p. m. Rectal examination after the birth of the first baby showed the second head presenting. The second baby was delivered in the OLA position at 7:07 p. m. There was an excessive amount of bleeding at this time and rectal examination revealed that the placenta had separated and was lying in the vaginal canal. A large bag of waters was present and the presenting part of third baby was not felt. A hand was inserted vaginally, the bag of water was ruptured, a foot of the third baby found, and the baby extracted in the SLA position at 7:12 p. m. Two placentæ were expressed immediately after the birth of the third baby. Birthweight of the babies were 2,100 grams, 1,650 grams, and 1,620 grams. They were all females. The mother made a normal uneventful afebrile convalescence. Blood pressure rapidly came down to normal, and the urine cleared of albumen. The patient weighed 112 pounds and was in good physical condition when discharged from the hospital.

Case 2.—Mrs. M. L., a primipara, aged twenty-six, was first seen on December 10, 1937. Her past history was essentially negative. She had had an appendectomy at nine years of age. There was no family history of any multiple pregnancies. Menstruation began at 13.5 years, was always regular every twenty-eight to thirty days, lasting for four to five days. She passed no clots and had no pain. The last menstrual period was on August 27, 1937, and the estimated date of confinement was June 4, 1938. The patient weighed 108 pounds at the time of her first examination. She stated that she was having moderate nausea and vomiting and that her breasts were enlarged and sore. She had no urinary symptoms. Her general physical examination was negative. Blood pressure was 120/80, urine entirely negative. Measurements were adequate. Notation on chart at the time of first examination was: "Fundus to level of umbilicus, unusually large for 3.5 months' pregnancy—cannot hear fetal heart, patient has felt no fetal motion." Patient was seen at regular intervals and because of the size of the uterus an x-ray was taken on February 25, 1938 (Fig. 2) and a diagnosis of triplet pregnancy made.

On March 26 the patient had a blood pressure of 136/90 and the urine was normal. She was given instructions as to her diet, rest, etc. On April 9 the blood pressure was again 138/90 and the urine normal. On April 16 the blood pressure was 138/92 and the urine showed 1 plus albumen. The patient was sent into the hospital on April 18 for observation and treatment. Blood pressure fluctuated between the above readings and 170/110, the urine, however, showed an increasing amount of albumen varying from .5 to 1.3 grams per litre. There were occasional casts and an occasional blood cell. Eyeground findings were nor-

*From the Department of Obstetrics and Gynecology, University of Minnesota.

mal. The patient gained a total of twenty-six pounds during her pregnancy. On April 29 at 2 a. m. labor started spontaneously, pains being moderate in severity and intensity.

At about 11 a. m. when the cervix was 5 to 6 cms. dilated, it was felt that the bag of waters was hindering the descent of the presenting part and it was ruptured artificially at 11:10 a. m. Patient continued in labor and delivered a normal female infant weighing 4 pounds, 5 ounces at 12:23 p. m. An episiotomy was done to prevent any undue pressure on the premature heads and to facilitate the subsequent breech delivery. The second bag of waters was ruptured artificially at 12:35 and the second baby delivered at 12:54 p. m. Following rupture of the membranes the presenting part came down with the cord prolapsed in front of it. The cord was pulsating and the second fetal heart was good so no concern was felt. The second baby was delivered as a persistent occiput posterior with a hand prolapsed beside the face. Following the birth of the second baby, the patient started to bleed abnormally and a diagnosis of premature separation of the placenta being assured, a hand was inserted and the third baby delivered by breech extraction. All the babies cried spontaneously. The two placentæ present were expressed immediately following the birth of the third baby. There was no abnormal bleeding, the patient being under careful observation for some time following the delivery. The patient had an uneventful afebrile convalescence and was discharged from the hospital at the end of ten days. Blood pressure at the time of discharge was practically normal, 130/80, and the urine showed only a trace of albumen.

Fig. 1. Case 1.

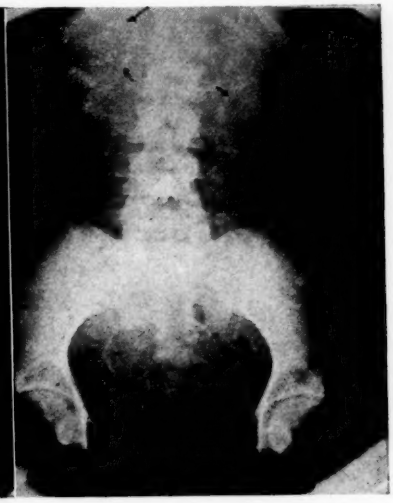

Fig. 2. Case 2.

The clinical course of multiple pregnancies when more than two infants are present seems to be particularly hazardous for both mother and babies. There have been a large variety of complications reported in the literature. The commonest complications reported in the mother are toxemias of pregnancy, premature delivery, hydramnios, premature separation of a normally implanted placenta, placenta previa and postpartum hemorrhage. In a number of recently reported cases of triplets, the presence of one or two papyraceous feti with only one of the three a normal baby has been observed several times. Malpresentations are common, interlocking in the course of delivery has been reported and placental anomalies are not unusual.

Prostigmine.—Pharmacologic experiments indicate that the prostigmine component of prostigmine compounds possesses some of the properties of the closely allied drug physostigmine. Its actions and uses are similar, but it has the advantage of being more stable. Apparently, it is as active as physostigmine in stimulating intestinal peristalsis and has a similar but somewhat diminished myotic activity. There is no satisfactory evidence that the symptoms produced by toxic doses of prostigmine salts are any less severe than those produced by comparable doses of physostigmine or its salts. Atropine is the antidote to prostigmine. Prostigmine preparations have been used experimentally for the prevention of atony of the intestinal and bladder musculature, and for the symptomatic control of myasthenia gravis. Prostigmine is available only in the form of its salts.—*New and Non-Official Remedies.*

HISTORY OF MEDICINE IN RAMSEY COUNTY

BY J. M. ARMSTRONG, M.D.

IN the year 1835, the Rev. Thomas S. Williamson, M.D., with other missionaries, arrived at Fort Sneling. Dr. Williamson was a graduate of Jefferson College, Canonsburg, Pennsylvania, in 1820, and of the Yale Medical School, in 1824. He was born in the Union District of South Carolina in March, 1800. Previous to his ordination as a Presbyterian minister he had practiced medicine at Ripley, Ohio. He, with others, was appointed by the Presbyterian and Congregational Churches through their joint Missionary Society to visit the Dahcotas with a view of ascertaining what could be done to introduce Christian instruction. Williamson was stationed at various points in Minnesota, or Michigan Territory as it was till 1838, when Wisconsin Territory was established. In 1846, he was at Kaposia, an Indian village located somewhat up river from the present site of South Saint Paul, and was still stationed there in 1851. As he was sent there to administer to both the spiritual and the physical needs of the Indians, it is probable that his medical services were required and used by residents of this vicinity; in fact, his account book shows memoranda of charges for services and medicines to residents of this vicinity during those years. Until 1838, however, the present site of Saint Paul was part of the government reservation and there were no settlers here except squatters until after that time. In his ministerial capacity Williamson performed on the 27th of May, 1835, at Fort Snelling the first marriage service in which a clergyman officiated within the present State of Minnesota, and, one may perhaps add, the first performed by a physician. It is not necessary to go further into Dr. Williamson's career here except to state that he played an important part in the early years of our history, as is evidenced by the frequency with which his name and letters appear in our histories, and the numerous papers he read before the Minnesota Historical Society. He also translated the Bible into the Sioux language. An interesting paper by him on "Diseases of the Dakota Indians" may be found in Volume IV of the *Northwestern Medical and Surgical Journal*, Saint Paul, 1874.* He died at St. Peter, Minnesota, June 24, 1879. To refer to his account book, one sees that his charges for medical services were modest and that he seldom received money for them, being paid mostly in beef, potatoes, and grain. An item for the year 1843 is of interest as it shows that Dr. Turner, of Fort Snelling, apparently was away on leave. This item is as follows:

"For attending on the Garrison and Indians for Dr. Turner, three months and eight days, $229.00. For private practice while living near Fort Snelling, $110.06."

The six cents must have come in some way through the price charged for drugs.

Fort Snelling, at first called Fort St. Anthony, was established as a military post in the year 1819, though the present site was not occupied until 1821. There have always been one or more army surgeons there, and their services were often sought by our early residents. Surgeon Edward Purcell was with the troops

*See also Sibley Letters in the Historical Society library.

that established the post. He was a Virginian, though Irish by birth, and entered the army in 1813, dying at Fort Snelling, January 28, 1825. He was the first United States officer to die in Minnesota, and again, perhaps one may say, the first physician. Purcell's activities will be taken up in a separate chapter. Purcell was succeeded at Fort Snelling by Surgeon B. F. Harney (entered the army in 1814, died 1858) with Robert C. Wood (1800-1869) as assistant surgeon. The latter became surgeon in 1829 and was married that year at Fort Crawford, now Prairie du Chien, to the oldest daughter of Col. Zachary Taylor (later President). Jefferson Davis (later President of the Confederate States) was his brother-in-law. Both Taylor and Davis, then a lieutenant in the army, were stationed at Fort Crawford. During the Civil War, Dr. Wood was Assistant Surgeon-General.† Other surgeons stationed at Fort Snelling were Nathan S. Jarvis (entered the army in 1813 from New York, died 1862), Fitch, in 1837, and George F. Turner, in 1843 (entered the army from Virginia in 1825, died 1854), Joel Martin, who was succeeded in 1849 by Adam N. McLaren (entered the army 1833, died 1874). Whether any of the last named attained to fame as physicians or surgeons is not known. Turner, however, is of particular interest, as his report on an epidemic of scarlet fever at Fort Snelling appears to be the first contribution to a medical periodical from Minnesota. One army surgeon, not yet mentioned, stationed at Fort Snelling was John Emerson (entered the army in 1833, discharged 1842), the owner of Dred Scott, the negro slave whose suit for freedom, because of his residence here, was carried to the Supreme Court of the United States and settled by the decision of Chief Justice Taney. Dr. Turner cared for the pioneer settler, A. L. Larpenteur, in 1847 or 1848, for typhoid fever, which is stated to have been very prevalent here then, as it was up to some thirty-five years ago. Perhaps another man is worthy of note here, though he played no part in the medical history of this state. In October, 1823, one John Marsh, a Harvard graduate of the preceding spring, arrived at Fort St. Anthony as tutor for the colonel's children and conducted the first school in Minnesota. While at the Fort, he studied medicine under Doctor Purcell; in fact at college he had taken courses in anatomy and some medical instruction with Dr. John Dixwell of Boston. It was Marsh's intention to return to Harvard at the end of two years and obtain an M.D. degree; but fate willed otherwise, for instead of returning to the East, he followed the frontier as it moved westward and finally, in February, 1836, found himself in Los Angeles. Being without funds, the most convenient occupation to adopt seemed to be that of a physician. So we find Marsh the first American to practice medicine in California. He had a colorful career and occupied a somewhat prominent place in early California history.‡

In 1838, the land east of what is now Seven Corners, Saint Paul, was opened for settlement and a few white people and half-breeds settled there, most of them engaged in supplying the soldiers and Indians with whiskey. In 1840, the commanding officer at Fort Snelling, in an effort to stop this nefarious trade, expelled from the military reservation, then extending to our present Seven Corners, those squatters still on the government land. Among those driven from the reservation was an Abraham Perret (Perry), a Swiss, who came here as early as 1827. He came from Lord Selkirk's unfortunate settlement on the Red River of the North. Perret lived about where the Ancker Hospital now stands. His wife, Mary Anne, who had seven children, enjoyed quite a reputation as a midwife, and it is stated that she was employed in that capacity several times by the army women at Fort Snelling, who for this reason urged the Commandant

†For biography see *Medical and Surgical Reporter*. Phila., 20:275, 1869.
‡John Marsh, Pioneer, by Dr. George D. Lyman, Charles Scribner's Sons, 1930.

not to expel the Perrets with the other squatters. One of Mrs. Perret's daughters, Adele, who became Mrs. Vetel Guerin (died December 21, 1914, aged eighty-seven years), also was called upon in the early days to serve her sex in the same capacity. The Guerin cabin was on the bluff side of Kellogg Boulevard just below Wabasha.

The first white child born within the present limits of Saint Paul was Bazille Gervais, born September 4, 1837 (died in Saint Paul, 1926). Who was the accoucheur there is now no means of knowing. The first white female child born within the present limits of our city was Cleopatra A. Irvine (Mrs. Richard L. Gorman), daughter of John R. Irvine. She was born March 1, 1844, in a log cabin which stood a few feet from the present northwest corner of Kellogg Boulevard and Franklin Streets. Here an Indian squaw and Mrs. Scott Campbell, a half-breed woman, acted as obstetricians. Mr. A. L. Larpenteur's first child, Mrs. Harris, was born there September 22, 1847, and Mrs. Scott Campbell was again the attendant. The Irvines were the second American family to settle there and the Larpenteurs the fourth, so that births could not have been frequent in the early forties. Mrs. Harris was the first female child born in Saint Paul after the town was plotted and received the name Saint Paul (July 25, 1847). Before that time the general locality was successively known as Kaposia, Pig's Eye, the nickname of Pierre Parrant, and later more specifically as Saint Paul's Landing, Saint Paul's, and finally Saint Paul.

From this time on perhaps the best plan of procedure for continuity will be to take up the medical history of the county by years, as it is easier to follow in that way.

1847

In this year, two physicians arrived in Saint Paul's; one came on July 15 to look over the ground and returned on October 15 to remain there the rest of his life. He was Dr. John Jay Dewey.

Dr. Dewey was born September 9, 1822, in Butternuts, now Morris, Otsego County, N. Y. His parents were Ebenezer and Lucy Webster Dewey, and the family, a Connecticut one, had lived in Lebanon till 1814 when they moved to New York state. Dewey's parents were neighbors of the parents of Dr. William Beaumont, at Lebanon. The father, in his day, was a lawyer of some note and it is said at one time tutored in Greek in Yale College. Doctor Dewey received his education at Hamilton Academy, which later became Madison University, and after completing his course there entered Albany Medical College at Albany, New York, where he graduated early in the year 1847, having attended the school for a period of three years, and having had Drs. Joel Lull and A. P. Strong of Laurens, N. Y., as preceptors for thirty-two months. Several years prior to this time his elder brother, Nelson Dewey, had removed to Wisconsin Territory, and he became the first governor of the state. Through his brother's influence, young Dewey came west after his graduation and went to Lancaster, Wisconsin, then the capital of that state, where he remained till he came to Saint Paul's. When Wisconsin was admitted to statehood it was obvious that a new territory would be organized to the west, and that the seat of government would be a desirable place to locate; still better would it be if one could arrive early and become established. It was surmised correctly that Saint Paul's would become the capital, and no doubt this circumstance induced Dewey to go there. In 1848, Dr. Dewey, with Charles Cavileer, opened the first drug store in Saint Paul's and the first in the area which became Minnesota Territory the next year. In 1849 he was elected to the first territorial legislature. He retired from the drug

business about 1854 and continued to practice medicine, though, having accumulated a sufficient amount of property to satisfy his needs, he never attempted to extend his clientele. On December 20, 1862, he was commissioned Assistant Surgeon, Ninth Minnesota Volunteer Infantry; he resigned September 11 of the following year and returned to Saint Paul. In 1852, he married Elizabeth Ann Barbour (nee Cannon). The late General Wm. G. LeDuc, of Hastings, who knew Doctor Dewey in 1850, said:

"Dewey was an excellent, quiet, undemonstrative man of sense, medium sized, stocky is the word, dark eyes and hair, and clean shaven in the early days."

About 1870, he retired from all business activities and led a quiet life till his death from pneumonia, April 1, 1891. His residence in the Directory of 1856-7 is given as "Saint Paul Street (now Olive) below Somerset," where he also had his office, and in this neighborhood he lived till the time of his death. He was a cousin of the late Admiral Dewey, U.S.N., and his son, Dr. James J. Dewey, who was born in Saint Paul in 1855. Dr. James Dewey graduated in medicine from Rush Medical College but retired from practice some forty or more years ago (died January 2, 1934). Dr. Dewey, Sr., retired from practice before the present Ramsey County Medical Society was formed. By the kindness of Dr. James J. Dewey and his sister, Mrs. George Bell, of Saint Paul, the Ramsey County Society possesses a photograph and autograph of Dr. John J. Dewey, his medical diploma, some of his instruments, matriculation cards from the Albany Medical College, and his military commissions.

Sometime in the year 1847 there arrived a young Virginian by the name of Wm. C. Renfro, a cousin of Henry Jackson (our first American settler, who came to Saint Paul in 1841). Renfro is said to have been a man of ability and education with pleasant and affable manners. He had studied some medicine but probably never graduated from a medical school and had never practiced medicine. Unfortunately, he was too convivial in his habits. On January 3, 1848, his body was found clothed only in his undergarments under a tree near the present northwest corner of Ninth and Locust Streets. It seems he rose in the night and started to town for another drink and was frozen to death. Nothing further seems to be known about Renfro. Possibly, one might say that he was the first physician who died in Saint Paul.

Since we have just recorded the first death of a physician in Saint Paul, we might also record the name of the first physician born there. Newspaper records state that Dr. John George Kittson died in Saint Paul, May 10, 1884. One paper gives his age as forty years and another as thirty-eight. The records at McGill University, however, show that he gave the date of his birth as August 16, 1844, and the place Saint Paul's, which was the name of Saint Paul at that time. He entered the medical school at McGill in 1864, but for some reason did not attend the session of 1867-68 and graduated with the class of 1869. He practiced medicine at Berthier, Canada East (Quebec). In 1875, he became the first chief surgeon for the Royal Northwest Mounted Police. He returned to Saint Paul broken in health, in 1882, and died at the home of his father, Norman W. Kittson. It is known that Norman W. Kittson did not take up his permanent residence in Saint Paul until 1854. Dr. Williamson's account book contains no record of Dr. Kittson's birth, so one might presume that Mrs. Abraham Perret or Mrs. Scott Campbell, who were here at that time, were present when he was born.

To divert again from the narrative, it may be stated that the first resident of Saint Paul to graduate in medicine was Freeborn F. Hoyt. The Hoyts came to

Saint Paul in 1848. Hoyt attended Rush Medical College in 1850, and after graduation established himself in Red Wing, where he practiced till he retired, some years before his death.

As previously stated, the army surgeons at Fort Snelling were frequently called upon professionally by the residents of Saint Paul's. There were other physicians available, notably Dr. Christopher Carli, of Stillwater, who settled there as early as 1841. Dr. Carli was frequently called over to Saint Paul. Mr. A. L. Larpenteur has related the following incident:

"In the fall of the year when my infant daughter was about a year old, she was taken with fits. We were much alarmed. Doctor Dewey was away so I sent to Stillwater for Doctor Carli. He came. It was cold weather and it took him two days, sometimes, to make the round trip, as it did this time. He came in, looked in the child's mouth, took a lancet from his pocket and lanced the child's gums. In twenty minutes the child was asleep. I could have done it myself had I known enough. Sometime in the sixties we had a reunion at the Sawyer House, in Stillwater, of the old settlers and I sat next to Doctor Carli. I said to him, 'You damned old rascal (we old fellows do not care what we say to each other) 'you robbed me.' On his wishing an explanation, I said, 'You charged me twenty-five dollars for lancing the gums of my baby.' He replied, 'It was twenty-five cold miles over there and I forgot I had to go home again, it should have been fifty dollars.' In those days there was no direct road to Stillwater and the so-called road was mostly covered with hazel bushes at that."

1848

Only one physician, Charles William Wolf Borup, settled in Saint Paul in 1848. He never practiced medicine in Saint Paul, but when in the employ of the American Fur Company as a clerk he practiced medicine. A paragraph written by one of the missionaries follows:

"Dr. Borup, to whom our family is indebted for much kindness, requests—that you would procure and send in a box with the things for the mission, the following books—Bourgery, A Treatise on Lesser Surgery translated by W. C. Roberts and James B. Kissam, Essays on some of the most important articles of the Materia Medica by George Carpenter, W. E. Tuson, Dissector's Guide—Wood and Bache's Dispensatory of the U. S., latest edition. Also inquire the price of Lizar's Anatomical plates. It is difficult for him to obtain these books."

(S. Hall to David Green under date of February 12, 1835. From Archives of the American Board of Congregational and Presbyterian Missions.)

Dr. Borup was born at Copenhagen, Denmark, in 1806 and graduated in medicine in Copenhagen. He left Denmark, March 24, 1827, and went to the Danish West Indies, but did not like the climate there, having contracted yellow fever. He came to the United States in 1828. In 1831 he came west in the employ of the American Fur Company and resided at different times at Mackinaw, Fort Snelling, Leech Lake, Yellow Lake, and La Pointe. He was an accomplished musician, the Borup home being the social and musical center of the town in the early days. In 1852, he, with Charles H. Oakes, who came west in 1825, established the first bank in Saint Paul and the first in the territory. Dr. Borup died in Saint Paul, July 6, 1859. Several of his descendants are well known residents there.

1849

In 1849, Minnesota Territory and Ramsey County were organized and the town of Saint Paul incorporated. Many settlers flocked to the capital of the new territory and by the end of the year the population of the city was about 250 to 300. There were thirty dwellings by actual count on April 23. E. S. Seymore, under date of June 18, says:

"I could count 142 buildings including shanties and those under construction; all except a dozen were perhaps less than six months old—at that time there were five physicians."

These five men were John J. Dewey, already mentioned, David Day, Christopher Caldwell, Thomas R. Potts, and Nehemiah Barbour. However, in addition to these five there were two others who came to Saint Paul sometime during the year and may be regarded as more than transient visitors. Biographies of Dr. Day and Dr. Potts will appear later. For the present, we shall narrate only the occurrences relative to medical men and affairs as found in the *Pioneer* for this year. In the second issue of that paper, dated May 5, 1849, in addition to Dr. Dewey's card and an advertisement of Dewey and Cavileer, druggists (who sold tasteless castor oil, among other things), there appears the simple announcement —"Dr. Christopher Caldwell, Physician and Surgeon." This seems to be all that is known about Caldwell. Research and inquiry have revealed nothing more except that a man named Caldwell married a Miss Pierson in Saint Paul, that year. His name does not appear on the census rolls in 1850, so it is presumed that he must have left before that time. Perhaps he had the announcement placed in the paper intending to locate in Saint Paul but did not do so. In the issue of May 12 (third issue) the following notice may be found:

Dr. N. Barbour

The undersigned would respectfully notify the citizens of St. Paul and vicinity that he has opened a

Drug Store

and will keep on hand a good assortment of Drug Medicines, Paints and Dye Stuffs and will also Prescribe Medicines for all those who wish it according to the Eclectic practice, as taught in the Cincinnati Reformed College of Medicine.

This advertisement ran somewhat over a year, and in 1851 a similar announcement appeared stating that he had returned to Saint Paul and would resume practice. There is very little further to be found out about Barbour. He was known to the old settlers as a "root and herb" doctor. He was apparently still living in Saint Paul in 1854, but no more information concerning him is available.

The other two men referred to as being in Saint Paul that year appear to have been unpopular, at least with the editor of the *Pioneer,* as appears from the following items:

Run Away

From Saint Paul, without paying his honest debts, a person in the shape of a man calling himself Doctor Snow, formerly of Prairie du Chien. This is to warn all persons against this man's rascality.
Prairie du Chien *Patriot* please copy.

George Wells.

Sometime later a rumor became current that Dr. Snow had started for Germany, where he had received a handsome legacy, but the Prairie du Chien *Patriot,* noting this, remarked that it was generally understood there that Snow had gone to California. The *Pioneer's* next jibe was sharp:

"We all expected Snow to liquidate before running off, it seems quite evident from all we can learn that the Doctor has not been properly understood here."

This closed the record of Dr. Snow so far as it is recorded or remembered.

(To be continued in next issue.)

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J. R. BRUCE

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The A.M.A. House of Delegates Meeting

TO ONE who has never before witnessed the deliberations of the House of Delegates of the American Medical Association, the special session held September 16 and 17 at Chicago was a revelation. The appointment of committees to consider the resolutions submitted to the House, and the hearings of the committees which could be attended and taken part in by the delegates, assured opportunities for all delegates to be heard. The reports of the various committees later presented to the House were then accepted, modified or rejected. The final action of the House thus represented the majority opinion of the delegates from the states as well as is humanly possible. The idea, often expressed, that policies of the A.M.A. are dictated by a small group of officers, is untenable.

The final action of the House of Delegates has already appeared in *The Journal* of the American Medical Association and should be carefully studied by all physicians. The delegates handled a complicated subject very well. The newspaper reports gave the impression that the profession had stepped into line with the recommendations of President Roosevelt's Technical Committee on Medical Care. As so often happens, the lay press gave the wrong impression. Although the House of Delegates showed throughout its deliberations a desire to coöperate with government agencies in the wise expenditure of funds for the medical care of the needy, it does not recognize the need for a yearly appropriation of any 850 million dollars recommended by the President's Committee, and they reiterated their strenuous disapproval of compulsory state-controlled health insurance.

The House of Delegates again recommended the establishment of a federal department of health to consolidate the twenty-seven different public health activities of the government, with a secretary who shall be a doctor of medicine and a cabinet member. They also approved the expansion of Public Health and Maternal and Child Health activities along prevention lines only, and with due regard to economy.

Hospital expansion was recommended where need exists. The wise suggestion is made that the so-called private hospitals be subsidized for the care of the needy rather than that new hospitals be built. It has been shown that private hospitals throughout the country are only 60 to 70 per cent occupied and many are having financial difficulties.

The principle was announced that medical care of the indigent is a local problem and should be handled by local government from tax funds and with the coöperation of the local medical profession. Doubtless some communities and states may require federal assistance in the form of financial and technical aid, but no general federal subsidy is advocated. It is not difficult to appreciate that higher taxes only depress busi-

ness and increase the burden of the medical care of the indigent. It is wiser for the states to use every endeavor to improve economic conditions which affect the health of our citizens.

Heretofore the various hospital service insurance organizations have received little official support from our national organization. At this meeting, however, the movement which has shown a mushroom-like and healthy growth throughout the country was approved and, providing it does not include doctors' fees, its expansion is urged. Cash indemnity insurance plans to cover in whole or in part the costs of emergency or prolonged illnesses were deemed practical. It is not the occasional need for a doctor that proves a burden for the low income group, but the serious accident or prolonged illness which as a rule requires hospital care. One wonders whether insurance to cover this contingency would not be as popular as that covering hospital bills.

It can be seen that the recommendations of the House of Delegates agreed with the statements submitted by Dr. Braasch on the standpoint of the House of Delegates of the Minnesota profession as expressed at its special meeting September 11.

Pneumococcic Meningitis

THE invasion of the meninges by the pneumococcus is attended by a high mortality rate. This type of meningitis occurs most commonly as a complication of pneumonia, middle ear infections, and skull fractures. Rarely, the meninges may be attacked without any demonstrable primary focus. Until recently, all therapeutic procedures have yielded disappointing results.

Recent reports indicate that, with the introduction of sulfanilamide into the treatment of bacterial infections, a promising therapeutic approach for patients with pneumococcic meningitis has been made possible. Allan and his associates at the Johns Hopkins Hospital have had three patients with pneumococcic meningitis who recovered following the administration of sulfanilamide. Finland and his colleagues at the Boston City Hospital have also presented an important report concerning the use of sulfanilamide alone or in combination with specific antipneumococcic serum in the treatment of ten patients with pneumococcic meningitis, six of whom recovered. In contrast to these results, before the introduction of sulfanilamide, ninety-nine patients were treated at the same institution between November, 1929, and June, 1936, and none recovered. Many of these patients had been treated with specific antipneumococcic serum. These workers believe that a combination of sulfanilamide and specific antipneumococcic serum is more effective than either one alone. The principles of treatment which they have adopted at present include the administration of large doses of sulfanilamide by mouth or subcutaneously; the intravenous injection of specific antipneumococcic horse or rabbit serum; the intrathecal injection of the patient's own serum obtained after he has received the specific serum intravenously; and frequent drainage by lumbar puncture. Sulfanilamide need not be given intraspinally since it appears quickly in the spinal fluid in adequate amounts when given orally or subcutaneously. On the other hand, the specific serum must be introduced into the spinal canal, since it cannot be demonstrated in the fluid when given intravenously. Fresh human serum also must be introduced intraspinally in order to provide complement, which is necessary for the destruction of the pneumococcus. If the patient's serum is not available, small amounts of normal fresh human serum and specific antipneumococcic serum may be given. In one patient treated successfully in this manner, there were 20,000,000 colonies of pneumococci per cubic centimeter in the spinal fluid prior to treatment.

Although the number of patients treated by these workers is small, the results warrant the trial of their methods by others. It will be important to determine in the future whether a combination of sulfanilamide and specific antipneumococcic serum is not more effective in the treatment of cases of pneumoccic pneumonia than sulfanilamide or serum alone.

The paper of Finland and his associates* merits the attention of anyone interested in careful clinical investigation. The protocol of each patient is included with a discussion of the clinical, bacteriological, and immunological studies employed.

WESLEY W. SPINK, M.D.

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*Finland, Maxwell, Brown, John W., and Raugh, Albert E.: Treatment of Pneumococcic Meningitis: A Study of Ten Cases Treated with Sulfanilamide Alone or in Various Combinations with Specific Antipneumococcic Serum and Complement, Including Six Recoveries. New England Journal of Medicine, 218:1033, (June 23) 1938.

President Coffman

THE sudden passing of Lotus Delta Coffman, president of the University of Minnesota, ended the career of one who had reached the top in his chosen profession—that of an educator.

President Coffman was born on a farm near Salem, Indiana, January 7, 1875; graduated from the Indiana Normal School at Terre Haute, Indiana, in 1896; received his A.B. degree in 1906, and his A.M. degree in 1910, both from the University of Indiana. In his younger years he taught in country schools, acted as superintendent of schools, director of teacher training, and university teacher, until he took his Ph.D. degree at Columbia in 1911. From then on he taught,—first at the University of Illinois, from 1912 to 1915, when he came to the University of Minnesota. Here he was Dean of the College of Education for six years, until he was named fifth president of the University in 1921, to succeed Dr. Marion Leroy Burton.

During President Coffman's seventeen years as president, the University has shown tremendous development. The enrolment has doubled and the annual budget nearly so. Many new buildings, as well as several new departments, have been added to the University.

The qualifications of a university president have changed in recent years. Whereas formerly scholastic attainment in the dead languages used to be considered a prime consideration in selecting a university president, now he must be not only an educator but an administrator. President Coffman's training, first as teacher and later in administrative capacities, prepared him for the larger task of presiding over a university when the opportunity presented itself. Interested primarily in education, he still possessed an appreciation of the value of extra-curricular activities. His ability as an educator was recognized during his lifetime by honorary degrees from a number of universities. Minnesota has sustained a great loss in his sudden departure at an age when many more years of usefulness might well have been his lot.

We live worthily when we do work that helps to improve conditions of life for everyone.

STATUS OF THE GLEN LAKE SANATORIUM*

Donald C. Balfour, M.D., Director, Mayo Foundation
Rochester, Minnesota

I appreciate the privilege of being here on this occasion. It is most appropriate that those who have contributed to the growth of a great institution such as this should receive the recognition which is being given here this evening. I feel honored that I have the opportunity of joining in this tribute to Mr. Gale and Mr. Kingman and to those who have given such unselfish support to Glen Lake.

The control of such a devasting disease as tuberculosis is one of the great triumphs of medical science, and if one traces the history of this achievement he will be struck with the fact that it has paralleled the development of sanatoria. It is true that sanatoria for the care of tuberculous patients have been in existence for over a hundred years, because it was in 1791 that an infirmary for such patients was first founded in England, and up to the time of Koch's discovery of the tubercle bacillus thirteen sanatoria for the treatment of the disease had been established in England. In Germany the first hospital for the treatment of the disease was founded in 1853, and the earliest institutions in this country were "inspired by religious and humane motives as early as 1857." The beginning of modern sanatoria for the treatment of the disease in this country, however, is usually dated from the founding of the sanatorium at Saranac, New York, by Trudeau in 1885.

The change in the physical character of sanatoria during the past thirty years is evidence of the general improvement which has taken place in hospitals, but particularly emphasizes that the treatment of tuberculosis is on as scientific a basis as any other disease. Not so long ago the type of sanatoria was represented by a series of small, shack-like structures, and the treatment of the disease was largely a question of isolation, fresh air, and good food. That rest is the first principle in the treatment of tuberculosis was far from being generally recognized. It was found in later years that the principle of isolation was not necessary, and the tendency subsequently has been to construct sanatoria on the same general plan as any general hospital. As a matter of fact the modern sanatorium, as exemplified here at Glen Lake, with its laboratories and operating rooms and facilities for research and for the training of nurses, is so well constructed and equipped that little change would be needed to convert such an institution into a general hospital.

It has been interesting, too, to find that climate is not as important a factor in the treatment of the disease as was once thought, and it has become possible to construct sanatoria throughout all parts of the country so that those afflicted with the disease can obtain the best possible care without the serious disadvantage of going far from home.

The particular functions of a sanatorium, in contrast

*Presented at the dinner to honor the 25th Anniversary of the Hennepin County Sanatorium Commission held at Glen Lake Sanatorium, September 9, 1938.

to home treatment of the tuberculous patient, are the prevention of the spread of infection, the education of the patient and family and friends, the cure and arrest of the disease, particularly in advanced cases, the training of physicians and nurses for specialization in this field, the economic rehabilitation of the patient, and usefulness as a diagnostic center, furnishing facilities for preventorium care as well as for research and development of surgical methods of treatment of the disease. In all these functions the modern sanatorium has no superior and should continue to lead the way in further advances in our knowledge of this disease.

The control of tuberculosis has been accomplished to a great extent through methods of education and in this the sanatorium has had such a large part that public support and approval have been freely given. The fact that the majority of tuberculosis hospitals are community projects and have been developed with very little assistance from the federal government, which has limited its aid in tuberculosis largely to those patients who are direct wards of the government, will always be an example of what can be done by the community itself. As an example of the extent to which support by public funds is given, it has been shown that in 1908, 34 per cent of the sanatoria were supported by public funds, whereas in 1931 the figure had risen to 78 per cent. In other words, it is obvious that if the public can be convinced of the desirability of a program for the control of a disease and can see that the program is being satisfactorily carried out public support will not be lacking.

No better example of what a sanatorium should be and how it should be run in the estimation of both the public and profession can be found than here at Glen Lake, for it is generally agreed, among those who know, that in Glen Lake, Minnesota has a sanatorium which is unexcelled. The growth of Glen Lake has been steadily toward more scientific management of the disease, and the publications of the staff are recognized as being the observations of men of authority because of high scientific training and experience. An example of the standard of medical practice here is the accomplishment of the staff in carrying out successfully, for the first time in Minnesota, the complete removal of a diseased lung. The influence of such an institution on medical thought and practice is of the greatest importance, and I am glad at this time to express on behalf of the Mayo Foundation our appreciation of the opportunities which Glen Lake has afforded the members of our staff and the Fellows of the Foundation to study here. From the standpoint of graduate medical education we believe that no better opportunity can be found for scientific study of tuberculosis and its treatment than at Glen Lake.

Minnesota can well be proud of those who have made Glen Lake so outstanding. The tribute this evening to Mr. Gale and Mr. Kingman is significant since it is evidence of what can be accomplished when an institution is directed by men who have no other motive than to see that the highest possible medical service is rendered. I consider it an honor to join in the tribute to Mr. Gale and Mr. Kingman, who have had such a large part in the development of this institution.

In Memoriam

Axel W. Swedenburg

1873-1938

DR. AXEL W. SWEDENBURG, of Thief River Falls, died at his home August 20, 1938, from a stroke, at the age of sixty-five. He was born April 6, 1873, at Maiden Rock, Wisconsin. After finishing high school he acquired a Bachelor of Science degree from Valparaiso University. In 1903, he began the study of medicine at the Chicago College of Medicine and Surgery, and received his M.D. in 1907. The same year he married Elfrida Ericson, who passed away in 1913.

After finishing his internship, Dr. Swedenburg practiced at Ellendale, Minnesota, until 1910, when he moved to Thief River Falls. In 1914, he moved to Ashland, Oregon, where he practiced two years with his brother, Dr. Francis Swedenburg, returning to Thief River Falls in 1916.

On October 1, 1917, Dr. Swedenburg was commissioned first lieutenant in the Army Medical Corps and served at Jefferson Barracks and Fort Riley, being honorably discharged December 29, 1919. Since then he continuously practiced at Thief River Falls until two years ago, when he was forced to retire because of ill health.

Dr. Swedenburg was active in local affairs in his home town. He was one of the organizers and the first president of the local Rotary Club. He was affiliated with the local Masonic lodge and was a member of the Elks and Odd Fellows. He was a member of the Lutheran Church and was also a member of the Elmer J. Eklund Post No. 117 of the American Legion, which conducted a military service at the cemetery at the time of his funeral.

Dr. Swedenburg had practiced for over twenty-five years at Thief River Falls and was a member of the Red River Valley Medical Society, the Minnesota State and American Medical Associations. He also belonged to the American Railway Surgeons Association.

In 1919, Dr. Swedenburg was married to Mina Rock at Iowa City, Iowa. He is survived by his wife; one daughter, Mrs. Dorothy O'Connor of Saint Paul, two sons, Carl W. of Saint Cloud and Donald of Thief River Falls.

Fannie Kimball Fiester

1866-1938

Dr. Fannie Kimball Fiester died at her home in Austin, Minnesota, May 6, 1938, after a day's illness.

Dr. Fiester was born in West Randolph, Vermont, May 6, 1866. She received her early education in the city of her birth, and graduated from Northwestern University Women's Medical School in 1891. She received her M.D. from Hahnemann Medical College in 1893 and served her internship in the Iowa State Hospital at Independence, Iowa.

Locating in Austin in 1893, Dr. Fiester practiced continuously until the day before her death.

MEDICAL ECONOMICS

Edited by the Committee on Medical Economics
of the
Minnesota State Medical Association
W. F. Braasch, M.D., Chairman

LAST STEP IN THE SURVEY

Form 1-F, last step in the survey, went to all members of the Minnesota State Medical Association, September 24.

This form was designed to provide a check on the facts reported previously on Form No. 1. A careful record was to be made on it each day for the week beginning September 26 of the number of patients given care without charge, or those referred to agencies and from agencies for service.

This check is an essential part of the survey. Every member is urged to keep the record carefully and send it promptly to the secretary of his county or district society.

The American Medical Association has recommended that new appropriations for extensions of public health and medical programs be governed by the need in each community. It is the business of physicians to show where that need is.

THE SPECIAL SESSION OF THE HOUSE OF DELEGATES

THE recent special session of the House of Delegates of the American Medical Association was an epoch-making event in the annals of that representative body. There was much speculation on the eve of the gathering as to what action would be taken. Vague rumors were circulated that radical plans would be proposed by some of the members.

A plan for the spending of the 850 millions of federal money included in the National Health Program had already been adopted by one state medical society. Several of the state societies had encouraged the establishment of local health insurance plans.

New Plans Blossomed

In fact, during the last six months new plans for medical care have blossomed out almost daily in county medical societies throughout the land. The threat of governmental action, claims that many physicians were leaning toward socialized medicine, and criticisms of the attitude of organized medicine appearing in countless newspapers and periodicals all conspired to make some of us conservatives rather jittery as to what might happen on the morrow. That these influences affected the reactionary attitude previously held by many of the delegates is undoubtedly true.

Wisely Guided

However, as so often has happened in previous meetings of the House of Delegates, apparent crises were smoothly compromised and the action taken was generally satisfactory. The modus operandi for consideration of the problems confronting the delegates was well conceived and functioned exceedingly well. A general committee of twenty-five was appointed which was subdivided into groups of five. Each one of the subcommittees was assigned to the consideration of one of the five sections in the National Health Report. The choice of the general chairman, Dr. Walter Donaldson, was a wise and happy one, and he guided the deliberations of the various committees in a wise and masterly fashion.

The personnel of the subcommittees included many men who had given much previous time and thought to the subjects under discussion. The various subcommittees met separately to consider the subjects involved in the sections assigned to them. Opportunity was given to any delegate who so desired to appear before them and express his views.

The results of the deliberations and the final resolutions adopted undoubtedly represented the opinion of an overwhelming majority of the members present.

Sympathetic Attitude Adopted

Although the government health program was based on inadequate information and was not well considered and in spite of the fact that many of the members objected to many of its proposals, nevertheless they adopted a sympathetic attitude towards the "magnificent" objectives. Al-

though the House of Delegates endorsed the spirit of the proposals embodied in Sections I and II of the Health Program, important reservations were made which did not appear in the press. *These reservations included, first, that medical services should be expanded only in areas where they were needed, and, second, that those measures should be taken in coöperation and with approval of local medical societies.* These two very important reservations should make the proposals acceptable to the medical profession without hampering their application.

Insurance Principle Accepted

Another outstanding feature of the program adopted by the delegates is the acceptance of the principle of health insurance. While certain features of insurance never have been opposed by organized medicine, nevertheless its present attitude toward the subject permits more liberal interpretation than formerly. Reservations were made, however, which limit insurance to voluntary insurance and under the guidance of the local medical societies. *The resolutions definitely stated opposition to compulsory insurance with government aid.*

The approval of the wide expansion of the hospital facilities and the establishment of numerous diagnostic centers as suggested by the National Health Program was qualified. While the need of greater hospitalization was recognized in certain areas and in the care of certain diseases, nevertheless the hit-and-miss expansion as proposed was disapproved. A plea was made for more intelligent employment of facilities already existing and that any expansion be limited to rural areas and other fields as specified.

It is of interest that the Committee approved the principle of hospital insurance, which is being widely adopted throughout the country, and recommended it as a community project.

The Committee recognized the soundness of the principles of workmen compensation laws and recommended the expansion of such legislation to provide for meeting the cost of illness resulting from industry.

It is of interest that the Committee endorsed the principle of compensation for loss of wages during sickness.

3,000 Medical Society Plans

In the course of discussion, Dr. Leland called attention to the fact that over 3,000 plans are now filed in the Bureau of Medical Economics which have been proposed by medical societies and other medical agencies to provide for more adequate distribution of medical care. It is to be hoped that these plans and the action of the House of Delegates will refute insinuations which have appeared in many publications that the medical profession is not doing all it can to give the public the best possible medical care.

The sympathetic attitude of the delegates toward the National Health Program should refute accusations which have been made that the medical profession is opposed to health reform because of selfish motives. It should emphasize the fact that they had only one object in mind and that is the protection of the best traditions of medical practice.

In order to show their desire to coöperate with the federal authorities in carrying out the National Health Program, a standing committee was appointed by the speaker of the House for the purpose of conferring with them. It remains to be seen whether they will be met by the federal representatives with a similar spirit of coöperation.

W. F Braasch, M.D.

ACTION BY THE DELEGATES

The Board of Trustees was definitely instructed by the House of Delegates in Chicago to oppose the attempt initiated by Attorney General Thurman Arnold to convict the American Medical Association of monopoly. Monopoly was charged by Attorney General Arnold on the strength of opposition to illegal aspects of the Group Health Association of Washington, D. C., employees of the Home Owners Loan Corporation and an investigation threatened.

Any action that may fix upon the association this charge will be fought, if necessary in the courts of last resort.

The Delegates also unanimously rejected a resolution which would have encouraged medical societies to set up group plans and advertise them to the public.

A committee of seven physicians including Dr. Irvin Abell, Louisville, Ky., president; Dr. Henry A. Luce, Detroit; Dr. Frederic E. Sondern,

New York; Dr. Walter E. Vest, Huntington, W Va.; Dr. Walter F. Donaldson, Pittsburgh; Dr. Fred W. Rankin, Lexington, Ky.; and Dr. Edwin H. Cary, Dallas, Texas, was appointed to confer with federal authorities on methods of coördinating health and welfare activities of private practitioners and government health and medical workers.

AS MINNESOTA SEES IT

County officers, delegates and committees met in special session at the St. Paul Hotel, Sunday, September 11, to discuss the government health program and instruct Minnesota delegates to the Chicago session.

It is interesting to note that Minnesota's action anticipated in a general way the more detailed action taken at Chicago.

The Minnesota officers and committees—130 in all from all parts of the state—went on record to the effect that:

Minnesota's Platform

We in Minnesota are in sympathy with all intelligent efforts to help indigents and the people with low incomes.

We insist, however, that any plan adopted or any program proposed leave to the medical and health authorities of each state the exact form and extent of the program from that state.

We insist, also, that the right of freedom in choice of physician be preserved.

We are opposed to any form of tax-supported compulsory health insurance.

This action was taken after a day of discussion by state officers, by representatives of the State Board of Health and the State Board of Control now in charge of Social Security aids to public health and medical care, and others.

Excerpts from important talks made at the Sunday meeting follow.

Important Epoch

Dr. J. M. Hayes, Minneapolis, president of the Minnesota State Medical Association and presiding officer at the conference:

> We have reached an important epoch in our history. Are we or are we not going to let the politicians tell us what to do?

We have an arrangement in Minnesota whereby the medical profession is consulted on the expenditure of nearly all relief and welfare funds devoted to medical care and the public health. Our close coöperation with the official agencies has made it possible for any indigent person in Minnesota to receive excellent medical care when he needs it.

Our great problem is to fight false impressions created in the public mind by backers of the so-called National Health Program.

Doorbell Survey

This program is built largely upon statistics gathered in the W.P.A. "doorbell survey." And, in this connection, I would like to say a word about that survey. I had occasion, myself, to follow up the work in several families and I found that even where the people interviewed had been under the care of a naturopath they were listed as having received medical care. In many instances the people interviewed had answered carelessly and without any attempt whatever at truth or exactness. It is on the basis of such a study that the President's Inter-departmental Committee is now claiming the low income class lacks adequate medical care.

The public is easily deceived, however. Mr. Paul Kellogg declares in a recent issue of *Survey Graphic* that the W.P.A. survey was "the greatest medical survey in the history of American Medicine."

It is clear that we must find some way to counteract such statements in the public mind.

Dr. W. F. Braasch, Rochester, chairman of the Committee on Medical Economics: The program of the National Health Conference (where the President's committee proposed its program) was definitely a "set-up." The atmosphere was radical and antagonistic. When the representatives of organized medicine, Dr. Abell, Dr. West and Dr. Fishbein, told the conference what medicine has already done and what it proposes to do, they were greeted with silence. The doctors were outcasts and no representatives of banking or industry were present.

A number of different plans will be under discussion in Chicago next week. One, at least, will be very liberal. I hope you will instruct your delegates to carry down to Chicago a conservative, well considered program.

Successful Relationship

Dr. George Earl, Saint Paul, president-elect of the State Medical Association: Most suc-

cessful relationships in life are dual relationships. Notable among these dual relationships is that between doctor and patient which the politicians are trying, just now, to make into a triangular relationship of doctor, politician and patient.

We are of one mind, I believe, on the importance of maintaining the dual character of the doctor's relationship to his patient and also of maintaining the freedom of the patient to choose his physician.

We must remember that the public is not very intelligent on any program involving medical care. Also that the politician and social worker are its favorite teachers.

State Medicine Implied

Among other things, the new government program proposes establishment of 500 government-supported health and diagnostic centers in the United States. All of the elements of tax-supported state medicine are implicit in this proposal.

It is probable that we need very few such units in Minnesota because our level of practice is very high. It seems to me, therefore, that the government might rationally assist and enlarge our present facilities instead of building new hospitals and centers here.

Our problem is to present a rational plan that will provide adequate care and still not fasten upon us, unnecessarily a costly system of state-supported medical units.

Inference Untrue

I want to go on record here on the importance of counteracting the inference, attendant upon National Health Conference publicity, that physicians are opposed to the extension to everybody of good medical care. Nothing could be further from the truth.

We believe in the extension of public health services and we believe in insurance. We do not believe in tax-supported, government-controlled compulsory insurance because it will lead to medicine by politically controlled bureas with an overhead cost that may run to 50 and 60 per cent as it has in other countries.

In my opinion we must assure the public that we do stand for the best possible medical care for all the people. Let us show the public a positive program and a true leadership. Let us show them, further, that the doctors and not the politicians are their friends.

Minnesota's Record

Dr. E. C. Hartley, Saint Paul, director of Maternal and Child Welfare, State Department of Health: Since 1915 the maternal mortality in Minnesota has been cut in half. In 1937 the infant mortality was three for every 100 live births and more than 98 per cent were delivered by doctors—a record for the entire United States. Certainly the situation in Minnesota with regard to maternal and child health is an example for the rest of the nation.

If the laws suggested go through, considerable sums of money will undoubtedly be available for this work. I can assure you that any methods that may be adopted will be adopted in consultation with the state medical association. We have always assumed that our function in this respect was purely educational. I am sure that Dr. Chesley as executive officer would offer no other kind of service.

Dr. C. A. Stewart, Minneapolis: We have already a well-rounded public health program in maternal and child health, in nutrition, in prevention of crippling conditions, under Dr. Hilleboe of the State Board of Control, in our school health services, including vaccination and immunization with vaccines and toxoids supplied by the State Board of Health when they are requested. In the main, our child health program is adequate and additional funds would scarcely be needed in Minnesota except to supplement already existing services.

Sufficient Sanatoria

Dr. H. E. Hilleboe, Saint Paul, director of the Division of Tuberculosis and of services for Crippled Children, State Board of Control: There are now sufficient sanatoria to take care of all tuberculous patients in Minnesota. Additional funds for construction of sanatoria will not be needed in this state. Funds are needed, however, to supplement the follow-up care already instituted by the State Board of Control. There is need for further medical supervision of discharged patients, also for funds to provide the necessities of life for the families of patients. There is also a need for facilities to segregate tuberculosis patients among the insane.

There is no need to bring in federal funds to build additional hospitals for crippled children. At the present time social security funds are being used, temporarily, to hospitalize some crippled children in private hospitals. Within two years, however, there will be sufficient beds available at Gillette, the Shriners' hospital and the University hospital to care for the load.

Convalescent Home Needed

The Board of Control is especially interested, now, in providing domiciliary care and convalescent homes for indigent children. There are now 1,300 children in the state who were crippled from birth who need such care. Also there are a number of children with heart disease who should have convalescent care. There is a problem which we as physicians must face in time.

The chairman of the Board of Control has instructed me to inform the members of our association that he and the board will continue to follow the policies that have guided us for the past two years with regard to both the tuberculosis and the crippled child programs.

DR. PAUL O'LEARY, Rochester, member of the Committee on Syphilis and Social Diseases: Our Minnesota program for control of venereal disease has been functioning for 18 years and it has functioned so well that it has been set up as a model all over the United States. Some $43,000 has been devoted by the state to the program outlined by Dr. Chesley. Only about 177 doctors have taken advantage of the offer of free drugs which is a part of that program, an indication of the healthy condition that prevails in most communities.

A meeting like this should be of a constructive type. It is our business, now, to present a program for the health situation as a whole that will serve as a model just as our venereal disease program has served as a model in Minnesota.

Cancer Facilities Adequate

DR. MARTIN NORDLAND, Minneapolis, chairman of the Committee on Cancer: Control of cancer depends mainly upon early diagnosis and, certainly, there are ample facilities for early diagnosis of cancer in Minnesota. The importance of the cancer problem should be brought to the physicians, of course, and this has been a large part of the work of our committee.

DR. H. E. ROBERTSON, Rochester, member of the Committee on Cancer: I am strongly opposed to the carrying out of the recommendations concerning control of cancer which were included in the report of the technical committee and submitted as part of the program of the Inter-Departmental Committee.

Three Phases

The cancer problem resolves itself into three phases: one, research concerning the pathogenesis and cause of malignant growths; two, early and appropriate treatment of these growths (this point involves extensive education of both the layman and the doctor); three, the care of advanced cancer cases, particularly among the indigent.

The stimulus for the study of the pathogenesis and cause of cancer is sufficiently strong so that no urge by government agencies will ever be necessary. The reward of solid contributions in this field is sufficient in itself to keep every worker on his toes. The slightest hint that steps toward the solution of this problem are in sight has produced and would produce adequate funds from private resources to finance fully any such undertaking.

The early diagnosis and treatment of cancer involves a problem that must be solved wholly by the medical profession. In the education of doctors and laymen for the early handling of cancer cases, a program has been established for years by the American Society for the Control of Cancer. It is satisfactorily organized and evidences definitely good results. The establishment of centers throughout the United States for the exclusive study and treatment of cancer might need support from government agencies. But to turn over to these agencies the organization of such an intricate problem in education of doctors and patients and in the medical and surgical handling of cancer cases is distinctly a backward step. One has only to point to the thoroughly inadequate care given in the Veterans' Hospitals of this country to demonstrate the waste and uselessness of such a move.

"Cancer Asylums"

The care of advanced and largely indigent cases of cancer is likely to prove the final de-

velopment of most government plans in this field.

The demands of relatives of cancer-afflicted people and of the patients themselves, for free hospital care, especially when their condition is incurable, would make overwhelming inroads into funds established for cancer control. The result would be the establishment of cancer asylums throughout the country without material benefit to anyone except insofar as they provided free living for these unfortunate people. The resources now available in city hospitals and special cancer clinics are fairly adequate for handling this phase of the cancer problem. These are organized and controlled by medical men and no other lay substitute could be developed which would do a better job.

Supplement Hospitals

DR. PETER WARD, Saint Paul, superintendent of Miller Hospital and president of the Minnesota Hospital Association: The effect upon the private hospitals of further building of federal hospitals could probably be compared to the effect upon business in general of government interference. Hospital facilities in Minnesota today are sufficient, I believe, to take care of the needs of patients and doctors. There may be isolated communities where facilities are not ideal and government funds can be used as Dr. Earl suggests to supplement and amplify existing facilities.

Incidentally the Minnesota Hospital Association enjoys a membership of 98 per cent of all the hospitals in the state. In the Hospital world this is a unique record and evidence of the general excellence of our hospital facilities.

DR. ORIANNA MCDANIEL, Saint Paul, director of the Division of Preventable Diseases, State Board of Health: About one-third of the 2,000 or more pneumonia deaths that occur on the average each year in Minnesota could be prevented by use of serum. This would mean a saving of at least 340 lives each year.

Since federal money became available our board has set up a state-wide program of pneumonia control. The objectives were to assist physicians in diagnosing pneumonia and to furnish serum to needy persons. Typing centers have been set up in various parts of the state, 67 of them in the hospitals and others at the health unit districts. It is left to the physician to determine whether or not the patient is needy and should have the serum furnished by our board. Before serum is sent, sputum must be typed and a report telephoned to the Board. This work is in its infancy and much still remains to be done in the way of publicity both to the public and the doctors.

DR. A. J. CHESLEY, Saint Paul, executive officer and secretary of the Minnesota Department of Health: This situation has seemed serious to the health officers for a long time. We have tried to warn the practicing profession and I am glad to see that organized medicine is now thoroughly aroused.

One thing we must all remember. The public will look at health and medical problems from a national rather than from a local point of view. When Minnesota people hear on the radio that one-third of the people of the United States lack adequate medical care, that only five per cent of those who need it receive pneumonia serum, they are going to apply those figures, based on the national W.P. health survey, to Minnesota. We must not be too irritated on that account.

Figures Do Not Apply

Actually we know that those figures do not apply to Minnesota at all. Incidentally, even a United States Public Health official who was organizing the "doorbell survey" was unable to answer all of the 62 questions that untrained numerators were required to ask in their house-to-house survey. That fact indicates that the figures so widely quoted may not always be accurate or reliable.

It is practically impossible to find out by a survey just how much disease there is and to estimate on that basis just how extensive the medical facilities must be to take care of it. It IS possible, however, to compare death rates and, even more significant, the rate of deaths at which no physician is in attendance.

Few Unattended Deaths

We have just discovered in a study made recently by one of our staff that only one-tenth of one per cent of deaths in Minnesota last year were unattended by a physician. That is an important finding, especially when it is compared with the record of Mississippi, where

15.5 of the death certificates were not signed by a physician last year.

In a situation of this sort the State Board of Health is between two camps. We have already done our best to work with the doctors in Minnesota. On the other hand, when large sums of money become available to the states, congressmen demand that the people in their districts get their share.

If our present plan for utilizing federal funds can be followed, we shall be doing the best that can be done, I believe, at the present time. It should be remembered that federal grants are not flat grants, they must be matched by state funds.

Surgeon General Parran is a very competent man but he is on the spot. In any case, he is bound to confer with the conference of state and provincial health officers before he recommends appropriations.

Lesson from Canada

It seems to me that we might take a lesson from Canada's system and experience. In Canada, the final decision on all extension of medical care still rests with the organized medical profession. In some instances legislation that was not approved by the physicians has been passed. But the doctors refused to work under the legislation and new regulations have had to be made. Undoubtedly we can do the same thing, if we wish, in the United States.

Every Precaution

Every precaution must be taken to avoid the appearance of a selfish motive before the public.

We have done our best to provide a good program along sound lines in Minnesota. If we have failed it is not because we have not tried or because we have lacked the close cooperation of the medical profession.

DR. W. A. COVENTRY, Duluth: In all this discussion, too little emphasis is placed upon preventive medicine, it seems to me.

Our programs of preventive medicine should be carried on vigorously and amplified if possible. For instance, better mental hygiene would do a good deal to prevent overcrowding of insane asylums and considerable research should be done on this line alone. There is no doubt that hospitals should make some arrangement whereby they can give cheaper service, especially for the man in the low income group. The man on relief must, of course, receive care without cost.

DR. J. W. GAMBLE, Albert Lea: Doctors have been too close-mouthed. What we need now is some means of presenting our views to the public as impressively as the views of our critics have been presented. Newspapers, magazines, radio programs, have been full of criticism of the doctors. It is time for the doctors to take the public into their confidence.

DR. S. H. BOYER, SR., Duluth: We hear a great deal about "adequate medical service." But what is "adequate medical service"? Actually, we all know that service is a relative matter. What one person might consider adequate service another might regard as neglect. To one person four visits a day might be regarded as adequate service. To another one visit in two days might be ample. Adequate medical service is not an absolute but a relative matter and a matter which causes great difficulty whenever any group plan for medical service is contemplated.

DR. R. L. SCAMMON, Minneapolis, distinguished service professor of the graduate school of the University of Minnesota: We live in a mixed world. We use public water to bathe in a private bath with private soap. We go down to a breakfast which includes milk that is publicly inspected, in which, in fact, the only private thing is our spoons.

The real question is: where shall we draw the line between the things that are best as public functions and those that are best as private functions.

Medical Secrets

Medicine partakes conspicuously of both a public and a private function. It has always partaken of this dual function. In Rome there were codes for private functions of medicine. Even the barbarians set up their own codes. Such codes can be traced back to Greece and all over the civilized world.

Physicians, in fact, are often said to have medical secrets, to be in secret cliques. Now it seems to me, speaking not as a medical man —which I am not—but as a citizen, that these

medical secrets are essential for the physician. In the same manner, a wife is permitted to have secrets and is not required to testify against her husband. A solicitor also has secrets and if he discloses confidential information given him by his client he may be called before the bar association. In the field of religious belief there are also inviolable secrets. We all have the right of confession, of pouring out our woes secure in the knowledge that our confessor or minister will not be obliged to disclose our confidences.

For Decent Reserves

The same thing is true for the doctor in his private practice. A great many people come to the doctor with all of their personal difficulties and it is necessary for him to preserve that confidence.

No doubt more criminals might be caught if the lawyer or the wife disclosed the information in their possession.

The point is—and a point which I wish to make at the start—there is a certain set of reticences that must be preserved no matter what the cost. These reserves are what make decent society possible.

The advance in the public field of medicine has been most remarkable. But there is another field, the field of private practice, and upon it rests the dignity of man. And while we recognize the field of public medicine we know there are diseases which cannot be cured.

None of us are going to live forever. Our population is changing. We are dealing more and more with degenerative diseases which we can't cure yet. The public as a whole does not understand that fact and it is purely misunderstanding that they do not keep the matter clearly in mind.

Plans Must Be Localized

Now as to insurance, about which I have been asked to speak to you today: I believe an insurance scheme could be worked out in this country but it would have to be a highly localized scheme because our people are so different in different localities. I believe also that it could be worked out so as to keep what I consider to be one of the decencies of civilization, the right of the individual to go to the physician of his choice.

In my opinion, however, we cannot expect to give an extremely high grade of medical care under such a system, any more than we could provide an extremely high grade of shoes or of housing.

Wealth Not Great

This country is the richest in the world and also the most populous of civilized countries. In population it is not to be compared with France or Germany; and, looked at from the point of view of the population, its wealth is not so great.

In the state of Minnesota the last figures we worked out for 1933 showed that the average family income was about $1,750 and that only six per cent of the people were earning $2,500 or more a year. If the total income were divided among the entire population, it would yield a mere $90 a year per person. Obviously, the difficulty in "soaking the rich" is that we should have to use bird shot to do it.

Under a system of voluntary insurance it is possible that the people who need the service most will not purchase it. Certainly life insurance under the voluntary system has not worked. Even in our most prosperous year, 1929, we could insure only enough people to protect us for thirteen months.

"Like a Dinosaur"

In any case there is only so much you can give, just as there are only so many shoes and so much food. Probably it is better to spread it. Certainly it is better to have a local rather than a national system. This is a large country and, like a dinosaur, its head is a long way from its feet.

The system of insurance in effect in England is extremely variable. It works well in the North and not in the South and the fault probably is neither with the system nor the physicians but rather with the English people. The system is largely affected, of course, by the caste system. Many men are eligible and won't accept it because they do not want to be identified with the working class. In any case, it is a grave mistake to think that the system worked out in one country can be lifted and applied as it is to another.

Essential Factors

We have some interesting samples of health insurance in this country but we cannot fol-

low the plan of manufacturing people in any general form of insurance since the manufacturing companies select their people for insurance.

Perhaps the most important factors to be considered are these:

1. The plan would have to be localized.
2. It should not try to do too much, especially on the present income of the United States.
3. It would have to protect the confidential relationship between patient and physician.

In her recent report, Miss Roche gave 4½ per cent as the figure for medical expenditures in this country. That figure is probably wrong since it depends on a discredited study. But compare it with the German figure. In Germany about nine per cent of the worker's income is taken for health.

Everybody a Cousin

In the Scandinavian countries sickness insurance seems to work. I never could understand why, except that Sweden, for instance, is a small compact country and the age distribution is in the wealth-producing period. Also, Sweden did not get into the world war. Instead the Swedes devoted themselves to making money.

As in England, in Sweden everybody is cousin to everybody else. With that close relationship comes a sense of responsibility.

Professional Success

The difference between business and professional success is that success in business lies in making profits and success in a profession lies in the conduct of the job.

We should remember that there is all the difference in the world between maintaining standards which are occasionally violated and abandoning our standards altogether.

"BE ON GUARD"

(Monthly Editorial Prepared by the Medical Advisory Committee.)

Medicine is in the limelight. The public eye is focused on medical practice and medical men. Physicians and hospitals are being censured for the type of medical care which has been and is being given the people, especially those in the low income group.

Your Medical Advisory Committee finds that the great majority of the cases brought against members of our Association and reported to the committee come from the so-called indigent group.

It is easy for a lawyer to build up a case about this type of patient, sympathy is easily raised, and juries are readily swayed to give substantial verdicts.

Your committee warns you against any apparent neglect or indifference to them. Guard your words of advice carefully. Give the same careful consideration to their needs as you would to the man who can pay the highest fee, and keep records.

Remember, once having assumed the care of a case, you must continue attendance until discharged by the patient, until the patient has recovered, or another man has assumed the care with the consent of the patient or legal guardian.

MINNESOTA STATE BOARD OF MEDICAL EXAMINERS

Correspondence School Student Pleads Guilty to Unlawful Practice of Healing

Re: State of Minnesota vs. L. Leo O'Leary

L. Leo O'Leary, 23 years of age, entered a plea of guilty in the District Court, at Moorhead, Minnesota, on August 24, 1938, to an information charging him with practicing healing without a basic science certificate. O'Leary was arrested on August 16, 1938, following the filing of a complaint against him by Mr. Brist on behalf of the Minnesota State Board of Medical Examiners. O'Leary inserted a professional card in the Barnesville Record Review under date of July 7, 1938, reading as follows:

L. LEO O'LEARY
Drugless Therapy
Electro-Hydro Therapy Treatments
Dietetics and Baths
Office at Broadway Hotel
Hours 1-6 and by appointment
Phone 72

O'Leary also furnished the newspaper with a news item in which he referred to himself as a "drugless therapist" and that he had studied at the "National College of Drugless Physicians in Chicago." O'Leary was arraigned before E. U. Wade, Justice of the Peace at Moorhead, Minnesota, on August 17, 1938, at which time he waived his preliminary hearing and was held to the District Court under bond of $300.00, which he did not furnish. After eight days in the Clay County jail, O'Leary entered a plea of guilty before the Honorable Anton Thompson, Judge of the District Court. O'Leary stated that he started a three months correspondence course at the Swedish College of Massage in Chicago; that he was to pay approximately $30.00 for the course, but had only paid $3.00 and received a half dozen lessons. O'Leary maintained office hours only in the afternoon, devoting the mornings to the sale of aluminum ware. Judge Thompson,

on being fully advised of the facts, sentenced O'Leary to a term of one year in the Clay County jail, suspending the sentence and placing the defendant on probation upon several conditions, the first one being that O'Leary is to refrain from practicing healing in any manner unless he is licensed. The Court, also, ordered O'Leary to pay his personal obligations at Barnesville, Minnesota, on or before March 1, 1939, and to pay the Court costs within 60 days. Judge Thompson, in no uncertain terms, told the defendant that the practice of healing, without being licensed, amounts to swindling and the obtaining of money under a false pretense.

The Minnesota State Board of Medical Examiners wishes to acknowledge the very fine coöperation extended by Mr. James A. Garrity, County Attorney at Moorhead, Minnesota, in the prosecution of this case.

OF GENERAL INTEREST

Dr. E. C. Hanson, formerly of Park Rapids, is now located at Austin, Minnesota.

* * *

Dr. R. H. La Bree of Minneapolis has joined the staff of the Fergus Falls State Hospital.

* * *

Dr. A. B. Rosenfield of Pequot, has been appointed school doctor for the pupils of the Hibbing schools.

* * *

Dr. Arnold Settlage, formerly of Stow, Ohio, has recently become affiliated with the Worthington Clinic.

* * *

Dr. Harry Palmer, formerly of Eveleth, has located at Blackduck, where he is taking over the practice of Dr. D. J. Jacobson.

* * *

Dr. D. W. Cummings, son of the late Dr. D. S. Cummings of Waseca, has returned to Waseca for the practice of medicine, after an absence of several years.

* * *

Dr. C. O. Erickson, formerly on the staff of the Fergus Falls State Hospital, has been appointed Assistant Superintendent of the Rochester State Hospital.

* * *

Dr. D. J. Jacobson, formerly of Blackduck, has located in Bemidji, where he will continue the practice of medicine.

* * *

Dr. James Chessen, of Duluth, has accepted a position at the Washington University postgraduate medical school, in the department of otolaryngology.

* * *

Dr. D. J. Jacobson, formerly of Blackduck, and Dr. W. M. Haller, who has been associated with the Civilian Conservation Corps at Pike Bay, Cass Lake, have opened a suite of offices in Bemidji.

* * *

Dr. Gordon R. Kamman, Saint Paul, opened new offices at 1044 Lowry Medical Arts Building, September 10. Dr. Kamman limits his practice to neurology and psychiatry. His office hours are from two until five.

* * *

Governor E. A. Benson has appointed Dr. John Esser of Perham to the State Board of Health to succeed Dr. S. Z. Kerlan of Aitkin, who has left the state. Dr. A. G. Schulze of Saint Paul has also been appointed to the Board by the Governor to succeed Dr. N. G. Mortensen of Saint Paul.

* * *

Dr. V. E. Quanstrom has returned to Brainerd, where he will be associated with Dr. R. A. Beise. Dr. Quanstrom has recently completed several years of special work and study in surgery under Dr. Alton Achsner at the Tulane University, New Orleans.

After twenty-five years as chief of the Department of Obstetrics and Gynecology at the University of Minnesota, Dr. Jennings C. Litzenberg will complete his active service this month. An appreciation dinner will be held for him at the Minnekahda Club, Minneapolis, at 6 o'clock, Friday evening, October 14, the evening following the Homecoming Game with the University of Michigan. All former students and colleagues of Dr. Litzenberg are invited to attend. Application for tickets may be made to Dr. E. C. Maeder, 732 Eighth Avenue South, Minneapolis.

Silver Anniversary Dinner of the Glen Lake Sanatorium

The growth of Glen Lake Sanatorium, Hennepin County's tuberculosis hospital, from a three-cottage unit of fifty beds to a great, modern institution with facilities for the care of 750 patients, was reviewed at a silver anniversary dinner held at the sanatorium, September 9, honoring the twenty-five years of service of the Glen Lake Sanatorium Commission, its governing board.

E. C. Gale and J. R. Kingman, lay members of the commission, who have served continuously for the past twenty-five years, were guests of honor. Dr. F. H. Harrington, Minneapolis health commissioner, is the third member of the commission. Dr. S. Marx White and the late Dr. John W. Bell preceded him in that office.

The contribution which the sanatorium has made to the sum total of scientific knowledge on tuberculosis was emphasized by Dr. Donald Balfour, Director of the Mayo Foundation.

More than 350 representatives of local and state public health agencies, the medical profession, civic groups and church organizations attended the dinner.

NOTICE

Hereafter all communications to the Minnesota State Medical Association should be addressed to 493 Lowry Medical Arts Building, Saint Paul. Executive offices of the Association have been moved from 11 W. Summit Avenue, Saint Paul, to that address.

REPORTS and ANNOUNCEMENTS

MEDICAL BROADCAST FOR OCTOBER

The Minnesota State Medical Association Morning Health Service.

The Minnesota State Medical Association broadcasts weekly at 9:45 o'clock every Saturday morning over Station WCCO, Minneapolis and Saint Paul (810 kilocycles or 370.2 meters).

Speaker: William A. O'Brien, M.D., Associate Professor of Pathology and Preventive Medicine, Medical School, University of Minnesota.

The program for the month will be as follows:

October 1—Pellagra.

October 8—Visual Errors.

October 15—Influenza.

October 22—How to Gain Weight.

October 29—Loss of Teeth.

THE MINNESOTA MEDICAL ALUMNI ASSOCIATION PROGRAM

From 8:30 to 12:00 on Friday morning, October 14, there will be a program of clinics to be held in Todd Amphitheatre of the University Hospitals, Dr. Harold G. Benjamin, chairman.

Clinics

Dr. Ralph T. Knight, Associate Professor and Director of the Division of Anesthesia.

Dr. Horace Newhart, Professor of Otolaryngology.

Dr. Irvine McQuarrie, Professor of Pediatrics.

Dr. O. H. Wangensteen, Professor of Surgery.

Dr. J. L. McKelvey, Professor of Obstetrics.

Dr. Cecil J. Watson, Associate Professor and Director of the Division of Internal Medicine.

Dr. J. C. McKinley, Professor of Neurology and head of the Department of Medicine.

12:15 to 1:15—Luncheon in the Nurses' Hall at the weekly hospital staff meeting by courtesy of Mr. Ray Amberg, Superintendent of the Hospital.

1:15—Annual business meeting, Dr. Robert L. Wilder, President.

Additional Activities of the Homecoming Weekend

Appreciation dinner for Dr. J. C. Litzenberg, the retiring chief of the Department of Obstetrics, at the Minikahda Club at 6:00 p. m., Friday, October 14.

Following the homecoming game, Saturday, between Minnesota and Michigan, there will be a tea in the Nurses' Hall with dancing and refreshments. This event is sponsored by the nurses, who are inviting the attendance of student and graduate nurses, doctors, dentists, dental hygienists and medical technicians.

WOMAN'S AUXILIARY

Mrs. W. B. Roberts, President
2735 Irving Avenue South, Minneapolis.
Mrs. E. V. Goltz, Press and Publicity, St. Paul, Minn.

THE sixteenth annual convention of the Women's Auxiliary to the Minnesota State Medical Association was held in Duluth, June 29, 30, and July 1, with Mrs. J. F. Norman of Crookston, president, presiding. Registration at the Hotel Duluth, Wednesday, June 29, followed by the Executive Board meeting at 10:30 in the Royal Room of the Chamber of Commerce, opened the session. In the afternoon a delightful tea was given in honor of the visitors at the Woman's Club and the same evening a Public Health meeting was held in the Orpheum theater. Thursday morning at 10 o'clock the annual meeting of the Auxiliary was held at the Northland Country Club at which Mrs. M. G. Gillespie, president of the St. Louis County Auxiliary, gave the address of welcome with Mrs. C. L. Oppegaard of Crookston, responding. A memorial service was given by Mrs. W. W. Moir of Minneapolis. Reports from the various chairmen and county presidents were read and the meeting closed with the election of officers. A luncheon followed at the Northland Country Club, and members heard Dr. Howard W. Haggard, Associate Professor of Applied Physiology, Sheffield Scientific School, Yale University, speak on "The Social Side of Medical Progress." Newly elected officers were presented and the Auxiliary members were greeted by the newly elected president, Mrs. W. B. Roberts of Minneapolis. A post-convention Board meeting followed. The annual banquet was held at the Hotel Duluth at 6:30 that evening with Dr. J. M. Hayes, president of the Minnesota State Medical Association, as the toastmaster. Mrs. W. B. Roberts, the newly elected president of the Woman's Auxiliary, was presented and greetings were extended by Dr. Irvin Abell of Louisville, president of the American Medical Association, and an address by Dr. Howard W. Haggard. Dancing followed. Owing to the weather conditions the delightfully planned trip on Lake Superior had to be cancelled but a group of women enjoyed having luncheon on board the boat. The warm friendship and hospitality of the members of St. Louis County Auxiliary made up entirely for the lack of sunshine and pleasant weather conditions.

The following appointments have been made by the newly elected president, Mrs. W. B. Roberts. The medical advisory council will include Dr. J. M. Hayes and Dr. C. B. Wright of Minneapolis and Dr. W. A. Coventry, of Duluth. The advisory committee of the Auxiliary is composed of Mrs. Charles W. Mayo, Rochester; Mrs. A. A. Passer, Olivia; Mrs. Benjamin Davis, Duluth, and Mrs. Charles Bolsta, Ortonville. Mrs. W. W. Moir of Minneapolis has been appointed corresponding secretary and Mrs. M. S. Hirschfield of Duluth parliamentarian. Mrs. J. A. Thabes of Brainerd is historian. The committee chairmen chosen from various parts of the state are: Legislative, Mrs. E. A. Eberlin of Glenwood; Finance, Mrs. James Blake

of Hopkins; Public Relations, Mrs. A. F. Branton, Willmar; Hygeia, Mrs. W. W. Will, Bertha; Health Education, Mrs. H. E. Wunder, Shakopee; Press and Publicity, Mrs. E. V. Goltz, St. Paul; Exhibits, Mrs. Harrold Wahlquist, Minneapolis; Archives, Mrs. S. S. Hesselgrave, St. Paul; Printing, Mrs. Frederick Erb, Minneapolis, and Revisions, Mrs. E. C. Eshelby, St. Paul.

Members of the Social Committee are: Mrs. Martin Nordlând, Minneapolis; Mrs. E. M. Hammes, Saint Paul; Mrs. F. J. Elias, Duluth; Mrs. F. A. Figi, Rochester.

Elective members of the Executive Board include: Mrs. A. C. Baker, Fergus Falls, president elect; Mrs. John F. Norman, Crookston, past president; Mrs. Malcolm Gillespie, Duluth, first vice president; Mrs. J. J. Ryan, Saint Paul, second vice president; Mrs. G. E. Hertel, Austin, third vice president; Mrs. George Earl, Saint Paul, fourth vice president; Mrs. R. J. Josewski, Stillwater, recording secretary; Mrs. Russell Noice, Minneapolis, treasurer, and Mrs. T. M. Fleming, St. Cloud, auditor.

Mrs. Roberts asked the members to pursue definite health projects in the coming year and to fulfill the Auxiliary's dual purpose of assisting the State Medical Association and the county auxiliaries. She stated that the scope of the Auxiliary's service had widened from the original function of promoting fellowship and mutual understanding within the medical profession to include, now, an effort to create better understanding among lay groups of what the medical profession is trying to do for public welfare.

At the request of the Minnesota Medical Association, the Auxiliary will give special attention this year to the need for immunization against communicable diseases. The Auxiliary will continue its support of the campaign to control cancer and the fight against tuberculosis. Members are urged to undertake, in their everyday contacts, to spread the gospel of regular and thorough physical examinations by competent physicians as a preventative measure. Mrs. Roberts recommended popularizing legitimate and reliable health magazines, such as *Hygeia*, published by the American Medical Association, and *Everybody's Health*, issued by the Minnesota Public Health Association. As a special project, she suggested that the Auxiliary sponsor or stimulate interest in the showing of health motion pictures. "Any legitimate and ethical means at our command should not be overlooked to emphasize the unselfish and willing devotion of the honest medical practitioner to a suffering world."

CLASSIFIED ADVERTISING

FOR SALE—Well established practice in town of 2,500 near Twin Cities. Air conditioned office equipped with x-ray. Specializing. Address A-50, care MINNESOTA MEDICINE.

WANTED—Position as office secretary and laboratory technician in doctor's office or laboratory technician in clinic or hospital. Experience. References. Address A-48, care MINNESOTA MEDICINE.

WHY PAY HIGH OFFICE RENT when you can get more space and better accommodations for less money in the Elliot Building, 8th Street and 8th Avenue South, Minneapolis. Centrally located; convenient to hospitals and outside restricted parking zone. Equipped with x-ray and clinical laboratory. Address A-49, care MINNESOTA MEDICINE.

MINNESOTA STATE MEDICAL ASSOCIATION

Eighty-Fifth Annual Meeting

June 28, 29, 30 and July 1, 1938

Duluth, Minnesota

HOUSE OF DELEGATES

First Meeting
Tuesday Afternoon, June 28, 1938

THE first session was called to order by Dr. W. W. Will, Bertha, speaker of the house, at 3:30 p. m., Tuesday, June 28.

Following brief greetings from Dr. Irvin Abell of Louisville, Kentucky, president of the American Medical Association, and a report from Dr. F. J. Lexa, Lonsdale, chairman of the Committee on Credentials, showing a quorum of members to be present, Reference Committees were appointed and committee reports assigned to them as follows by the speaker:

Scientific Reference Committees

Medical Education Reports

A. E. Cardle.....Minneapolis
(Appointed to act as Chairman in place of Dr. C. J. Ehrenberg, who was absent because of illness)
J. R. Aurelius.....St. Paul
P. J. Hiniker.....Le Sueur
H. A. Roust.....Montevideo

Miscellaneous Scientific Reports

C. L. Roholt.....Waverly
P. M. Gamble.....Albert Lea
F. H. Magney.....Duluth
C. O. Maland.....Minneapolis
C. A. McKinlay.....Minneapolis

Non-Scientific Reference Committees

Credentials Committee

F. J. Lexa.....Lonsdale
B. A. McIver.....Lowry
E. A. Thayer.....Truman

Lay Education Reports

F. J. Elias.....Duluth
(Appointed to act as Chairman in place of Dr. J. W. Helland, who was absent)
H. C. Cooney.....Princeton
B. A. Smith.....Crosby
E. J. Wohlrabe.....Springfield

Medical Economics Reports

M. C. Piper.....Rochester
G. I. Badeaux.....Brainerd
H. W. Goehrs.....St. Cloud
J. C. Jacobs.....Willmar
A. G. Liedloff.....Mankato

Officers and Council Reports

S. A. Slater.....Worthington
E. S. Boleyn.....Stillwater
W. F. Braasch.....Rochester
A. J. Lewis.....Henning
J. F. Norman.....Crookston

State Health Relations Reports

A. H. Zachman.....Melrose
O. W. Holcomb.....St. Paul
R. H. Wilson.....Winona

By motion duly seconded and carried, reading of the minutes of the last meeting of the House of Delegates was dispensed with and the meeting was recessed at 3:40 p. m. to permit the Reference Committees to consider and prepare their reports on the committee reports submitted to them.

The meeting was re-convened at 7:55 p. m. by Speaker W. W. Will.

DR. WILL: I think we are all in full agreement that the House of Delegates wields a most far-reaching influence in our state. As I look over the group before me I see many who have been active in the affairs of our Association in the past and I am encouraged to believe that all have been elected because of a keen interest in the welfare of organized medicine. I hope that all of you will make detailed reports of the business that is transacted here at the first meeting of your respective societies. I hope, also, that all of you will feel free to take an active part in the discussions and to make any criticism or suggestion that may occur to you, both as to the business under discussion and as to the conduct of the meeting. One of our councilors remarked to me today that he was surprised at the valuable suggestions offered by delegates at a preliminary group meeting in his district. If it is timidity that prevents the delegates from offering suggestions here, may I ask you gentlemen not to be timid. This is your meeting; it will be your fault if our discussion tonight does not cover the things in which you as delegates are interested.

Following a report by Doctor Lexa, chairman of the Committee on Credentials, which was accepted by the House and which showed that a quorum of members was present, Speaker Will called upon Dr. George Earl of St. Paul, Chairman of the Council, for a report of the day's Council meetings.

Doctor Earl reported as follows and his report was accepted by the delegates:

REPORT OF THE COUNCIL

Three hospital or medical service plans on the prepayment basis were discussed and motions that we secure more information about them were duly passed. They included the American Benefit Association plan, a plan offered by a commercial insurance company; the Hawaii Medical Service Association, sponsored by a group of laymen and some doctors acting as individuals; the Toronto Medical Society plan sponsored, as indicated, by the medical society of Toronto.

An estimate was submitted by R. R. Rosell, executive secretary of the Association, showing that this Annual Meeting will undoubtedly pay for itself and that it will be unnecessary to draw upon the fund of $1,500 allotted in the budget to Annual Meeting expense. An increase of 95 members over last year was also reported by Mr. Rosell.

The Minnesota Social Hygiene Institute of Minneapolis, likewise reported upon by Mr. Rosell, was thoroughly investigated by Dr. A. J. Chesley, executive officer and secretary of the Minnesota Department of Health and found to be a lay organization without qualified medical advice or sponsorship, organized with-

out consulting any of the constituted health authorities for the purpose of public health education on venereal disease. The Council directed that an article on the subject be prepared with the approval of Mr. F. Manley Brist, attorney for the Association, and printed in MINNESOTA MEDICINE.†

It was agreed that copies of the 1938 Roster should be sent as usual to judges of the district courts and of the probate courts of Minnesota for their information and assistance.

It was suggested that members of the Council keep in touch with members of the State Legislature and also with Minnesota members of the House and Senate in Washington. They were urged to express their feeling about current policies that concern medicine or public health, to keep legislators informed about the policy of organized medicine on all these matters and particularly to express their appreciation for the efforts of these legislators to safeguard American medicine and protect the public health.

It was agreed by the Council that the fiscal agency account as reported upon by the Finance Committee is in excellent shape and that the financial condition of the Association as reported upon by the treasurer has been also entirely satisfactory so far this year.

The Council approved the organization of a club to be called "The Fifty Club" and to be made up entirely of members who have been licensed to practice fifty years in Minnesota. These members will be honored as a group by the Association in general on appropriate occasions.

The Council also voted a letter of thanks to be sent to Dr. J. T. Christison and Dr. W. F. Wilson for their gift to the Association of old copies of MINNESOTA MEDICINE and of the *St. Paul Medical Journal* so that files of Association publications might be complete in our state headquarters.

It was decided unanimously that a distinguished service award should be presented on occasion to members of the Association whose contribution to the work of the Association merits such recognition. The following resolution accompanied this action:

"RESOLVED that the Minnesota State Medical Association should provide an appropriate token to be awarded on occasion to members of the Association who have rendered special, valuable and distinguished service to the Association; also, that selection of candidates for this award be left in the hands of the Council."

Other resolutions passed by the Council which are of special interest to the delegates are quoted herewith:

"WHEREAS, the Finance Committee of the Minnesota State Medical Association have carefully investigated the books and records of the Minnesota State Medical Association with the assistance and advice of their auditor, Mr. Byers, and found all entries on the books and records of said Association to be true, correct and proper, and

"WHEREAS, the 'inventories' submitted by the Chairman of the Council have been fully explained and discussed with Mr. Byers, auditor, and it is understood that the items of furniture on this list are in the possession of the Minnesota State Medical Association and that the equipment has been fully accounted for, and

"WHEREAS, all trade contracts have been individually investigated and have been found without exception to be to the financial advantage of the Association, therefore be it

"RESOLVED, that our secretary, E. A. Meyerding, M.D., be highly commended for the manner in which he has handled all Association affairs, and be it further

"RESOLVED, that an expression of appreciation be extended to Doctor Meyerding for the efficient and competent service he has given the Minnesota State Medical Association, and that he be asked to extend this appreciation of the Minnesota State Medical Association to his office staff and business associates for their assistance."

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"WHEREAS, the Finance Committee of the Minnesota State Medical Association has thoroughly investigated the costs of the publication of MINNESOTA MEDICINE by the Bruce Publishing Company, and has also obtained independent estimates on printing and office editorial work, and

"WHEREAS, they have found that the present costs are in no way excessive, although certain suggestions for economies may be suggested by the Editing and Publishing Committee, be it

"RESOLVED, that the Council of the Minnesota State Medical Association extend to the Editing and Publishing Committee and to the Bruce Publishing Company their sincere commendation and also their gratitude for the services rendered in such a faithful manner over these many years in developing and producing a journal of exceptional merit."

It was suggested that the earlier action of the House of Delegates, setting apart the Herman M. Johnson Memorial Fund in perpetuity for a lectureship which should appropriately commemorate the work of the late Doctor Johnson and directing that only the income from the fund be used for the purpose, be recalled and re-emphasized at this meeting.

The committee reports, designated under the general title "Medical Education Reports" and reviewed by the Scientific Reference Committee under the chairmanship of Dr. A. E. Cardle of Minneapolis follow:

COMMITTEE ON CANCER

The Committee on Cancer and the Council of the Minnesota State Medical Association have extended their coöperation to the Women's Field Army of the American Society for the Control of Cancer as a means of educating the public in the prevention and cure of cancer.

As part of this coöperation a specimen talk for use of physicians in addressing lay audiences on the subject of cancer was prepared by the committee and sent to every member of the Association with a letter from the committee setting forth its relationship and that of the Council to the Women's Field Army.

It was agreed that county and district medical societies should be requested to coöperate in the educational campaign of the Women's Field Army, also the Women's Auxiliary and that the Councilor in each district should be chief advisor as to plans and policies.

It was also decided that a Speakers' Bureau to be used by the Field Army should be on file at the State Office and that county medical societies in each instance should be consulted as to whether the speaker chosen is satisfactory to them.

It was determined by the Council, meeting with the Committee on Cancer, that the executive committee of the Women's Field Army should consist of the chairman of the Committee on Cancer, the State Commander of the Women's Field Army, the president-elect and secretary of the Minnesota State Medical Association, the state chairman of the American Society for the Control of Cancer, the state treasurer of the Women's Field Army, the chairman of the Committee on Public Health Education of the State Medical Association and representatives of the Field Army, which should be selected by the women's organization and approved by the Committee on Cancer and the Executive Committee as originally constituted. This committee held its first meeting in June, 1938.

Two state-wide cancer meetings under the auspices of the Women's Field Army were held during the year.

One was held in Minneapolis, December 8, with Mrs. Marjorie B. Illig of New York, national commander of the women's organization and Dr. F. L. Rector of

†The article appeared on page 584 of the August, 1938, issue.

Evanston, field representative of the American Society for the Control of Cancer, as guest speakers.

The other was held on the University of Minnesota campus with Dr. C. C. Little, managing director of the American Cancer Society, as principal speaker.

MARTIN NORDLAND, *Chairman*

The Reference Committee recommended acceptance of the report, recorded its appreciation of the interest and coöperation of the Women's Field Army and urged that all members of the Association make use of material available at the State Office to extend cancer education and coöperate with their local committees which are working on the cancer problem. The report was accepted.

COMMITTEE ON DIABETES

Revision of the booklet "Diabetes, How to Make It Harmless" was discussed at a meeting of the committee, June 4, and delayed by decision of the committee because treatment is in a state of flux at present. Members will study revision during the coming year. They propose, also, to draw up a series of short paragraphs for lay education on control and treatment of diabetes; to ask approval of the delegates for an effort to obtain a dietitian or nurse dietitian to be paid out of relief funds for the education of diabetic relief clients; to attempt to determine the attitude of industry toward diabetics and their employment.

H. B. SWEETSER, JR., *Chairman*

The Reference Committee recommended acceptance of the report, suggested that the problem of obtaining help for the education of relief clients is a local problem and should be handled locally, and agreed with the committee that the medical profession should stand ready to help both employer and employe to solve the diabetes problem as it relates to industry. It was further noted that the diabetes booklet in its present form is valuable and should be distributed continuously while the process of revision is carried on. The suggestion was made, however, that the term "harmless" be avoided in the title of the revised publication. The report and suggestions of the Reference Committee were accepted by the delegates.

COMMITTEE ON SYPHILIS AND SOCIAL DISEASES

The work of the Committee on Syphilis and Social Diseases is largely advisory at present since there seems to be no need, currently, to expand the venereal disease program of the State Board of Health in Minnesota; furthermore, no funds are available for any additional program.

The program of the State Board of Health has been well established for many years and has the approval of the Committee. At the suggestion of representatives of the American Social Hygiene Association, a special educational campaign has been carried on jointly in two or three localities of the state by the Junior Chamber of Commerce and the local medical society. The campaign carried on in Saint Paul by the Ramsey County Medical Society and the Junior Chamber of Saint Paul was notably successful.

Current public interest in the control of venereal disease has been utilized by fakers and commercial organizations, among the latter being the Minnesota Social Hygiene Institute, which proved, upon investigation, to have no qualified medical backing. Every effort should be made to eliminate unnecessary and unauthorized undertakings of this sort.

S. E. SWEITZER, *Chairman*

The Reference Committee approved the report, commending the committee for its work, and the delegates accepted it. The hope was expressed that the committee would continue the work of investigating non-medical organizations that might in the future attempt to exploit the program of venereal disease control.

Dr. T. H. Sweetser, chairman of the Committee on State Health Relations, said from the floor that the State Board of Health, from whose meeting he had just come, would consider the venereal disease program the next morning in the light of the new legislation on the matter just passed by Congress. The Board had expressed itself as anxious to have members of the Committee on Syphilis and Social Diseases present at the morning meeting so that they might have the opinion of the committee as well as of the Council, which had also been invited to attend. Members of the Board also suggested, according to Doctor Sweetser, that the House of Delegates might wish to make some official statement, concerning lay associations that are collecting money, ostensibly to further the venereal disease program but actually for commercial purposes.

The speaker recommended that the Committee on Syphilis and Social Diseases attend the State Board of Health meeting and make whatever recommendations to the House that they should see fit.

COMMITTEE ON DEAFNESS PREVENTION AND AMELIORATION

Activities of the Committee on Deafness Prevention and Amelioration during the past year have included exhibits at the state meeting of 1937 in Saint Paul and at the Minnesota State Fair in September of the same year. Also demonstration hearing surveys in several colleges and communities, in connection usually, with public health or parent-teacher meetings. The committee also worked for passage of a bill to provide means for a more adequate public health program including hearing testing in the schools. The bill failed of passage but much interest was created in the problem, particularly of hard-of-hearing children in the schools.

Increasing interest in acquirement of modern equipment for testing hearing on the part of schools has been demonstrated in the past year. In the opinion of the committee every community having a school population of 2,000 or more should own its own equipment for testing hearing. The need is especially urgent in rural districts.

The work of the committee should be continued and a reasonable grant made to carry out its activities.

HORACE NEWHART, *Chairman*

The Reference Committee approved the report, commending the committee for its work, recommended acceptance of the report and appropriation of the grant requested for continuance of the work. It was suggested that any information in the possession of the committee on mechanical devices for testing the hearing and also for the aid of the hard-of-hearing be placed at the disposal of the profession. The report was accepted.

Doctor Newhart emphasized in a supplemental discussion of his report the need for additional funds. He emphasized, also, the need to rouse local interest in each community in the work of the committee. It is the hope of the committee that a state-wide program

can be established within the next few months; but it cannot be done without the active aid and leadership in each locality of members of the profession. The co-operation of the delegates was earnestly invited.

COMMITTEE ON MATERNAL AND CHILD WELFARE

With the collaboration of the Committee on Maternal Welfare and the Committee on Hospitals and Medical Education of the State Association, also of the University of Minnesota, the Minnesota Department of Health conducted the first series of postgraduate courses, so-called "refresher courses," in obstetrics and pediatrics in the state in May and June of 1937. These courses were sufficiently successful to warrant similar courses this year but with the difference that the 1938 courses were all given on one day instead of a weekly intervals. In 1937 the courses were given in Worthington, Brainerd, St. Cloud, Fergus Falls, Grand Rapids and Mankato. In 1938 they were given in Crookston, Winona, Hibbing, Willmar, Albert Lea, Fergus Falls, Worthington and Bemidji. The total attendance in 1937 was 1,005, a weekly average of 167½. Complete attendance reports have not been obtained as yet for this year's courses, but the indications are that the course was well received.

The newly organized State Society of Obstetrics and Gynecology held its last semi-annual meeting in St. Paul in April. Largely as a result of the efforts of this society the Central Association of Obstetricians and Gynecologists will hold its annual three-day meeting in Minneapolis next October, a further evidence of the growing interest in maternal welfare in Minnesota.

Maternal mortality rate for 1937 in Minnesota was 3.0 per 1,000 live births and the infant rate was 40.8. This is by far the lowest rate reported by any state in the United States.

R. D. MUSSEY, *Chairman*

The Reference Committee commended the work of the committee, endorsed the postgraduate lecture courses and recommended their continuance and the acceptance of the report by the delegates. The report was accepted.

The committee reports designated as "Miscellaneous Scientific Reports" and reviewed by the Scientific Reference Committee under the chairmanship of Dr. C. L. Roholt of Waverly, follow:

COMMITTEE ON HOSPITALS AND MEDICAL EDUCATION

The new experiment in postgraduate medical education, now in its second year at the Center for Continuation Study, University of Minnesota, under the direction of Dr. W. A. O'Brien, also, the postgraduate courses in obstetrics and pediatrics carried on in key communities throughout the state under the direction of the Division of Child Hygiene of the State Board of Health, are new centers of activity in this type of education.

This committee and the State Office have assisted in both programs. The committee also consulted with Dr. Hamilton H. Anderson of the Council on Medical Education and Hospitals, American Medical Association, concerning a survey of postgraduate education in Minnesota which later was made in coöperation with the State Office. A résumé of this survey was printed in the *Journal of the American Medical Association*, March 5, 1938, page 136B.

It seems obvious that the postgraduate courses sponsored and financed solely by the State Association are not now needed in Minnesota.

JAMES B. CAREY, *Chairman*

The Reference Committee recommended acceptance of the report with the following substitution for the final paragraph of the report:

"It appears to the committee to be too early to state that postgraduate courses sponsored and financed solely by the state association are not needed."

The delegates accepted the report with the change recommended.

SUB-COMMITTEE ON PUBLIC HEALTH NURSING

In conjunction with a representative of the Public Health Nursing Department, a set of Orders and Policies to guide nurses employed in boys' and girls' summer camps was formulated and copies sent to the members of this committee for their suggestions and approval. All committee members heard from approved, and mimeographed copies of the subject matter will be sent to nurses so employed.

H. F. BAYARD, *Chairman*

In compliance with the recommendation of the Reference Committee the delegates accepted the report.

COMMITTEE ON MILITARY AFFAIRS

The current status of Medical Reserves in Minnesota may be detailed as follows: For the Army—6 Colonels, 13 Lieutenant Colonels, 12 Majors, 48 Captains, 304 First Lieutenants. For the Navy—24 Lieutenant Commanders, 12 Lieutenants and 3 Lieutenants, Junior grade.

The profession is to be commended for careful examination of C. M. T. C. applicants. Medical Reserve Officers who are designated by the Chief of Staff of the First Reserve Area to serve on Boards for Appointment and Promotion are urged to adhere to regulations strictly so that personnel in the Reserve Corps may be of the type desired for service in the Army.

The ninth successive Medico-Military Inactive Duty Training Course of the Mayo Foundation was held this year at Rochester with 32 states represented and a total of 1,164 enrolled during the past nine years for the course. Several other medical centers throughout the country have also instituted courses recently. They are patterned after the original "Skinner Plan" employed since 1929 by the Mayo Foundation.

Funds allotted by War Department to the Surgeon General have been inadequate for training of medical reserve officers ordered to Flight Surgeon's School for practical training. Also, the War Department ruling grounding all but five of the 285 flight surgeons in the regular army, national guards and reserves, will handicap the aviation medical service, in the opinion of the committee, since pilots should be observed under flying conditions as well as on the ground. Every effort should be made to have this ruling annulled.

Reserve officers should avail themselves of all opportunities to participate in army maneuvers, since much can be learned when serving with the troops in the way of organization, instruction, sanitation and many other details that cannot be learned from books. Medical officers participating in the Fourth Army Maneuvers at Fort Ripley last August acquitted themselves creditably. In the four concentrations of the army there were 1,803 reserves, of whom 16 per cent were in the medical department, ordered to active duty.

Twenty-six medical reserve officers are on CCC duty in Minnesota at the present time. A number of officers on CCC duty have successfully passed army examinations and have entered the regular establishment for their professional careers.

Re-establishment of the medical R. O. T. C. on a voluntary basis at the University has resulted in an en-

rollment that is far below the enrollment when the training was compulsory. Only 17 medical students enrolled for the training last fall, with 16 for the winter quarter and 13 for the spring quarter. This training should be established on a compulsory basis in order to qualify students for leadership in any branch of the service of the United States in time of emergency.

The bill for amending the National Defense Act to provide uniforms and other allowances to the officers of the Reserve Corps is noted by the committee. It provides for an allowance for each hour of credit earned in Army Extension Courses by members of the Officers' Reserve Corps who are eligible for active duty in excess of the annual minimum of 20 and not to exceed $75 in one year, as well as allowance for uniforms.

Attention of all Reserve Corps officers in the association is called to the Annual Convention of the Association of Military Surgeons to be held at Rochester, October 13, 14 and 15.

LT. COL. F. L. SMITH, *Chairman*

In compliance with the recommendation of the Reference Committee the report was accepted by the delegates.

HISTORICAL COMMITTEE

Two more county histories and several other manuscripts of historical interest have been received by the committee during the past year.

Installments of the "History of Medicine in Minnesota" have appeared regularly since January, 1938, in MINNESOTA MEDICINE, and sufficient material is on hand to continue the installments for at least two years.

Criticisms and correction of the published material are invited so that, should the history later be published in book form, they may be incorporated in an appendix.

The committee will continue to gather data and hopes to receive additional manuscripts from individual members of the Association. It also wishes to thank the Council for its coöperation and support, which have made possible publication of the material.

J. M. ARMSTRONG, *Chairman*

Complying with the recommendation of the Reference Committee, the report was accepted by the delegates.

COMMITTEE ON FRACTURES

A definite fracture program for Minnesota is suggested by the committee to include the following:

I. Creation of a permanent State Fracture Committee to consist of a chairman, appointed by the president and one member from each constituent society.

II. Formation in each constituent society of a fracture committee which should have its representative on the state committee for chairman and which should draw up a definite fracture program for the society, including an annual fracture symposium to be held at one of the regular society meetings.

III. Adoption of the following statewide program to be carried out by the state committee in coöperation with the constituent societies:

A. *First Aid and Transportation.*

1. Adoption throughout the state of the Keller-Blake hinged, half-ring splint for the lower extremity, and the Murray-Jones hinged ring splint for the upper extremity, these splints to be of the size and specifications used by the United States Army.

2. Education of profession and public in use of the splints.

3. Equipment of ambulances throughout the state with these splints; also industrial plants. Hospitals should be equipped likewise for the purpose of exchange with ambulances when patients are brought in with the splints on, since the splints cannot be removed for some time and the ambulance must be on its way.

4. Coöperation with the Red Cross in its First Aid Station work throughout the state (splints are now available at these stations), with the Highway Department and the Boy and Girl Scouts in their First Aid educational program.

B. *Diagnosis.*

1. Adoption of standardized surgical directions to insure proper films and promotion of frequent x-rays to determine reduction and progress of healing.

C. *Hospital Equipment.*

1. For treatment of fractures of the long bones all hospitals should have overhead frames for suspension and traction, simple splints, Thomas arm and leg splints, equipment for skeletal traction; a portable x-ray apparatus.

D. *Treatment.*

1. Liberal constructive discussions should be allowed at society and hospital staff meetings.

It is further suggested by the committee that every annual meeting program should include a fracture symposium and that an exhibit showing first aid in transportation, x-ray diagnosis, hospital equipment, treatment, et cetera, should be arranged by the committee for each meeting.

O. W. YOERG, *Chairman*

The suggestion of a permanent state fracture committee was especially commended by the Reference Committee and, complying with its recommendation, the report was accepted by the delegates.

COMMITTEE ON ASPHYXIA AND ASPHYXIAL DEATH

The increasing use of automobiles and of gas in the home has increased both morbidity and mortality from asphyxia and the committee notes a growing need for the medical profession to give special thought to the subject.

Carbon monoxide is the chief source of poisoning. Most common causes are illuminating gas, exhaust gas from internal combustion motors and coal gas from defective furnaces or stoves.

One thousand asphyxia deaths are estimated to occur weekly in the United States, of which 50 per cent are due to carbon monoxide inhalation, either accidental, suicidal or homicidal. The interiors of about 5 per cent of automobiles on the highways have been found to contain a sufficiently high concentration of carbon monoxide to produce such symptoms as dizziness or collapse. The blood of about 49 per cent of 426 garage employes studied recently was found positive for carbon monoxide, the percentage in the blood of the positive reactors ranging from 5 to 30 per cent.

Recognition of chronic poisoning which develops insidiously due to repeated exposure to sublethal concentrations of gas over a long period of time is important, as well as recognition of acute poisoning. Much still remains to be learned about the subject, but it has entered today into the domain of everyday practice, and the committee hopes to make studies, formulate plans for public education on the subject which may in time serve to reduce the incidence of asphyxia and asphyxial death.

A. E. CARDLE, *Chairman*

Stressing the importance of further study in this field and the need for funds to carry out such work, the Reference Committee recommended acceptance of the report. The report was acceptd.

Committee reports designated "Lay Education Reports" and reviewed by the Non-Scientific Reference Committee under the chairmanship of Dr. F. J. Elias

of Duluth acting for Dr. J. W. Helland of Spring Grove, follow:

COMMITTEE ON PUBLIC HEALTH EDUCATION

There is good reason to believe that public health education is the greatest problem that faces the doctor today. When the neglected illness is thoroughly investigated, it usually develops that ignorance or carelessness and not actual lack of medical facilities was the cause of the neglect. The conclusion is inescapable that public health education is fundamental to the solution of the medical problem of this country rather than subsidies to physicians, new laws or new taxes.

It becomes increasingly clear to members of this committee, furthermore, that it is the doctors and not the nurses, social workers or lay health agencies who must direct the educational work.

The Committee on Public Health Education carries on certain state-wide activities which can best be handled from state headquarters. These activities have expanded but will not be truly effective until every individual member is supplementing them by his own efforts in his own community—by initiative in bringing preventive measures to his people, by working intelligently with local health and welfare agencies, and by individual instruction which will bring the people in his community to the doctor promptly, whether or not they are able to pay full fees for his services.

If the patient's income is not sufficient to pay full private fees then the doctor himself must know all of the facilities of the community and state in order to utilize the aid of welfare and relief agencies efficiently for his patient.

Where improvements are needed the doctor must be the first to work intelligently and conscientiously with the responsible officials to improve the situation.

Certainly it is illogical and unjustifiable to embark upon radical and expensive legislative changes until our established agencies have had a chance to show their effectiveness for all the people.

Committee activities for 1937-1938 include the following:

1. The *News Service* prepared under the auspices of the editorial subcommittee which goes weekly to all newspapers in Minnesota, designed especially to provide health instruction and instruction on disease prevention.

2. *Speakers' Bureau* made up of a list of capable speakers from all parts of the state on file at the State Office and available for talks on health and preventive medicine before lay groups of all kinds.

3. *College Lecture Course* designed to reach young men and women in the colleges, who will be the teachers and professional men and women of the future. A series of four or five talks given annually in the majority of the colleges of the state, honorariums and traveling expenses of speakers paid by the Minnesota State Medical Association, arrangements and booking made by the Minnesota Public Health Association.

4. *Speakers' Library*, a file of material maintained at the State Office for use of speakers who are requested to make public health talks before lay audiences.

5. *Hygeia, Everybody's Health.* After a lapse of several years *Hygeia* is now being sent to the members of the State Legislature by order of the Council. Through a special arrangement with the Minnesota Public Health Association, *Everybody's Health* will go with it at a special rate secured for both publications.

6. *4-H Club.*—Annual physical examinations of county contestants for state honors among 4-H Club members in Minnesota. More than 200 boys and girls were examined in 1937 by a group of 11 specialists. Physicians' time is compensated out of the budget of this committee. Arrangements are made by the Minnesota Public Health Association, which also contributes use of its headquarters.

7. *Literature.*—A folder called "Your Child's Health," which was prepared under the supervision of the Editorial subcommittee, was distributed widely in the state this year in coöperation with the Minnesota Public Health Association.

Attention of the members is called especially to the large number of agencies and campaigns independent of Organized Medicine that are now directing their attention to public health education and promotions. In general, these agencies have enlisted the advice and assistance of the State Association. They have great potentialities for good but only if sponsored and directed by physicians. Chief among them are: The Women's Field Army of the American Society for the Control of Cancer; the Syphilis and Venereal Disease campaign sponsored nationally by the United States Public Health Service and the American Social Hygiene Association; the Pneumonia campaign, a campaign for universal typing of pneumonia cases and use of serum for appropriate cases sponsored by large insurance companies and health agencies everywhere and locally by the Minnesota State Department of Health; the Maternal and Child Health program sponsored nationally by the Committee on Maternity and Child Health and materially assisted by new programs financed by Social Security funds—the film "Birth of a Baby," departure in education by motion picture, marked the campaign this year; the Diabetes control campaign, sponsored by a special society in New York fostered in Minnesota by the State Association.

The practicing physician must be thoroughly informed on the objectives and accomplishments of all of these campaigns and programs. Beyond all this, he must be an apostle in his own community to extend information concerning all medical services and all accepted preventive measures. Much is demanded of him, but much will be lost, also, to himself and to the public he serves if he fails to assume this obligation.

L. R. CRITCHFIELD, *Chairman*

SUB-COMMITTEE ON RADIO

Considerable interest has been shown by county medical societies during the past year in the possibility of establishing radio programs in addition to the state association sponsored broadcasts of Dr. W. A. O'Brien from WCCO. In accordance with an action of the Council the committee has encouraged this interest and assisted in obtaining broadcasting material. Arrangements are now under way looking to the possibility of extending Doctor O'Brien's broadcasts by special wire to station KDAL in Duluth.

From May 8, 1937, to June 11, 1938, inclusive, this committee sponsored 42 radio talks by Doctor O'Brien over WCCO in Minneapolis. In addition, there were joint broadcasts on the last Saturday of each month with the Minnesota State Dental Association, amounting to 12 in all. The speaker was Dr. W. A. O'Brien, Associate Professor of Pathology, Preventive Medicine and Public Health of the University of Minnesota. As in the past, the radio station made no charge for the use of its facilities.

The subjects for the period included:

Child Health Day, Some Major Health Problems, Nervous Exhaustion, Avitaminosis, Water Cures, Diverticulitis, Fourth of July Injuries, Dysentery, Pre-School Examinations, Coronary Occlusion, Sore Throat, Diphtheria and Smallpox, Duodenal Ulcer, Insomnia, Heart Disease, Hand Infections, Dietary Dangers, Acute Abdominal Conditions, Diabetes Mellitus, Emotional Stability, Tuberculosis, Nasal Obstruction, Typhoid Fever, Public Health Objectives, Pneumonia Types, Measles Prevention, Early Tuberculosis, Infant Feeding, Scarlet Fever, Asthma in Children, Acute and Chronic Alcoholism, Geriatrics, Communicable Disease Control, Early Diagnosis Campaign, Glaucoma, Brain Tumors, Periodic Health Examinations, Air and Sun, Research and the Hospital, Chronic Illness, and Burns.

On April 2 the committee also sponsored a special broadcast commemorating the tenth anniversary of this radio health education series. Speakers at the regular broadcasting period in the morning were Dr. J. M. Hayes, president of the State Association, Mr. Max Karl, Director of Education of WCCO, and Dr. Robert Burns, chairman of the sub-committee on Radio, together with Doctor O'Brien. At noon representatives of the medical organization, civic organizations, the state dental association, the radio stations, the University of Minnesota and the press were invited to a luncheon to commemorate the event. The Minnesota State Medical Association enjoys the distinction of sponsoring the oldest local broadcast except the market report to be given from Station WCCO. More than 500 talks have been given by Doctor O'Brien, and the program continues to have excellent following. In spite of the fact that there is no attempt to solicit mail, there is a regular flow of questions from listeners. In addition, Doctor O'Brien receives numerous requests to speak in person before all manner of organizations, also to participate in broadcasts sponsored by other organizations and agencies.

The Committee desires to thank Station WCCO for its unfailing courtesy and coöperation and its sincere effort to maintain a definite place on the air for the program. The time, 9:45 a. m. Saturday, has been occupied continuously for many months.

R. M. BURNS, *Chairman*

SUB-COMMITTEE ON SPEAKERS' BUREAU

Speakers and materials have been supplied to all organizations that have requested the service. As far as possible speakers have been chosen from within the neighborhood from which the request came for obvious reasons of economy, though it is occasionally necessary to send speakers on special subjects from a distance.

Many more speakers could be utilized in this work and any person who can give a good talk himself or who knows of someone who is qualified is requested to communicate with the Sub-Committee on the Speakers' Bureau.

F. H. MAGNEY, *Chairman*

With regard to the report of the Committee on Public Health Education and the two sub-committee reports the Reference Committee declared as follows: That the report of the committee as a whole portrays evidence of an exhaustive and well-defined program and of outstanding accomplishments; that the college lecture courses described therein show that a series of well chosen subjects has been delivered by eminently well-qualified members of the profession; that the continuance of the excellent type of education carried on by the radio sub-committee and Doctor O'Brien is of vital importance to the Association and that extension of the program, particularly to the Duluth station, would be a valuable asset if it could be arranged; that in connection with the work of the Speakers' Bureau, a speakers' bureau should be created within each component society with a view to extending health education by platform talks throughout the state. In accordance with the recommendation of the reference committee the report was approved.

At the invitation of the Speaker, Dr. F. J. Savage of Saint Paul gave the following supplementary report in the absence of Dr. L. R. Critchfield, chairman of the Committee on Public Health Education:

I wish to express the thanks of Doctor Critchfield to Doctor Meyerding and his staff and to Mr. Rosell and his staff for their help in the past year in making our program a success. I wish also to give due credit to the affiliations with the Minnesota Public Health Association in putting over the work and to hope, also, that the association may continue.

The committee reports designated as "Medical Economic Reports" and reviewed by the Non-Scientific Reference Committee unnder the chairmanship of Dr. M. C. Piper follow:

COMMITTEE ON MEDICAL ECONOMICS

Members of the Medical Economics Committee and the sub-committees, as provided in the recently adopted constitution, held their first general meeting on Sunday, April 3, of this year in Saint Paul. This meeting was quite unique in the annals of medical organization since the work of the economic sub-committees which, though distinct, often overlaps and causes resultant confusion, could thus be coördinated and programs adjusted. Each sub-committee held its own round table discussions in the course of the morning, calling upon officers, councilors or representatives of other sub-committees for assistance as it might be needed. A general luncheon meeting for all followed, at which the Survey of Medical Facilities was outlined and discussed. Among the speakers were Dr. R. G. Leland, director of the Bureau of Medical Economics of the American Medical Association, Dr. C. B. Wright, trustee and Dr. R. L. Scammon, chairman of the Minnesota State Planning Board.

Details in the conduct of the survey were largely left in the hands of the Executive Secretary, Mr. R. R. Rosell, by the Committee on Medical Economics, which has general supervision of the work. Following is a brief summary of progress:

Information concerning scope and purpose was given initially in the *Journal of the American Medical Association.* The proposal was made first in Minnesota at the February County Officers' Conference, and since then it has been repeatedly publicized in MINNESOTA MEDICINE and in bulletins from the Executive Secretary's office.

Much credit goes to Secretary Rosell for his energetic conduct of the Survey, both from his office and in the field.

Council members have been asked to assume responsibility for the study in their own districts and several have held councilor district meetings to explain requirements to constituent county societies and to stimulate them to complete their portion of the work.

As a result, the Survey has made satisfactory progress in Minnesota. It is in advance here of many states, but much still remains to be accomplished, and this meeting should afford an opportunity for anyone who wishes it to get information and assistance. An exhibit on the survey and proper methods of filling out the Forms is on view in the exhibit hall.

The work of the editorial sub-committee has continued with the able supervision of Mrs. Fitzgerald, and we trust that the members are carefully reading the medical economics columns in which progress in medical economics is publicized each month. Members of the editorial sub-committee are Dr. W. F. Braasch, Dr. A. R. Barnes, Rochester; Dr. A. N. Collins, Duluth; Dr. Lennox Danielson, Litchfield; Dr. E. A. Meyerding, Saint Paul; and Dr. E. S. Platou, Minneapolis.

W. F. BRAASCH, *Chairman*

SUB-COMMITTEE ON PROFESSIONAL EDUCATION IN MEDICAL ETHICS AND SOCIAL AND ECONOMIC TRENDS

Education of undergraduates of the University of Minnesota Medical School in subjects related to medical ethics and to social and economic trends has been

under discussion. Heretofore lectures on these subjects have been given periodically to sophomores. Dean H. S. Diehl of the University Medical School is now working on a schedule of similar lectures for seniors which shall include also, at the suggestion of the committee, consideration of medical jurisprudence. The committee recommends that sterilization by vasectomy, except for purely medical reasons, be considered unethical practice by the House of Delegates.

ERLING W. HANSEN, *Chairman*

MEDICAL ADVISORY SUB-COMMITTEE

The Medical Advisory Sub-Committee has had numerous meetings with various other groups interested in lessening of malpractice suits against members. Articles have appeared in MINNESOTA MEDICINE, papers have been given at various society meetings for the purpose of better coöperation among members. A detailed report is to be given verbally before the delegates at this meeting.

B. J. BRANTON, *Chairman*

SUB-COMMITTEE ON STATE HEALTH RELATIONS

The usual assortment of problems related to its work have been referred to this committee and the committee has handled them in coöperation with other committees and with officers of the State Society. We have kept in close touch, also, with the State Board of Health, a representative of the committee having been present at virtually every meeting of the Board.

A survey of medical care at the State Tuberculosis Sanitorium was made by this committee in response to a request of the State Board of Control made to the Council and referred to us. This survey consumed a great deal of time and effort and was, we trust, satisfactory to those concerned. Thanks are especially due to Doctors Tuohy and Geer, who worked with the committee in the undertaking.

The committee is now making a preliminary study of the possibility of developing a program of periodic health examinations for Legionnaires that will be satisfactory to the profession. The request for assistance came from the Rehabilitation Committee of the State Department of the Legion, and we are coöperating with this committee. Various officers of the state association have been kind enough to work with the committee in this preliminary study.

T. H. SWEETSER, *Chairman*

SUB-COMMITTEE ON LOW INCOME AND INDIGENT PROBLEMS

There are three classes to be considered in any discussion of the problem of ability to pay for medical services.

First: Those who are unable to pay any fee whatever. We believe it is the obligation of the federal, state and local governments to provide adequate medical care for this group. In Minnesota this problem has been well handled.

Second: Those who are able to pay moderate fees but are not able to assume unusual obligations incurred by sickness and its accompanying misfortunes; this is the largest group of all.

Third: Those who are able to pay for services rendered. They are omitted for obvious reasons from discussion at this time.

It is generally agreed that medical care of the second group, the "low-income group" is the real problem, and it varies in every part of the United States. Virtually every state in the Union has devised and tried out schemes for more adequate care of the low income group. Many of these schemes have failed. Some have helped in the solution of the difficulty in certain localities. The American Medical Association has watched the progress of all these schemes and has carefully correlated them with their effects; but no national solution has been found or advised either by the federal government or by the association, though the American Medical Association has volunteered to cooperate with the government in an endeavor to find a solution to the problem.

Various plans for Hospital Insurance are now in operation, such insurance being handled by the hospital groups without outside aid. If some plan of sickness insurance should be devised that would apply in all parts of the United States, the medical profession would demand some part in management of the program. It is a well known fact that the political management of sickness insurance would be a disaster, as it has proved to be by experience with such "set-ups" in foreign countries.

That furtherance of preventive medicine is a function of the federal governmnt is generally agreed. America leads the world in this field today; but much still remains to be done. Why not a program directed toward less sickness as a means of reducing the costs of medical care to all? Is not our problem essentially one of disease prevention with good or better medical care to all, rather than one of medical fees?

Surveys on medical care have been conducted in many states and cities by lay people without the aid of the medical profession. It is well for us to have their side of the story, but as in all other stories, there is another side. And the American Medical Association, with its state affiliates, is making an intensive survey by questionnaires to physicians, hospitals, nurses, health departments, welfare agencies, public and parochial schools and through colleges and universities to discover as nearly accurate data as possible on the needs.

Perhaps from all this a real evaluation of needs and costs to the low income group may be elicited. Then, possibly, a scheme may be devised whereby sickness insurance may assist in providing care which is in the reach of all. There are two tenets that physicians will insist upon in any case. One is that the federal government shall not assume complete control of any plan that may be evolved; second, that the principle already held essential by the government, that the patient shall have free choice of physician, must be maintained.

Knowing well the burden placed upon those in the low-income group, the physicians of America are only too anxious to coöperate with the proper authorities to provide adequate and competent medical care to all.

The possibility of a program of rehabilitation of unemployable relief clients, similar to one now functioning successfully in West Virginia, has been discussed by this committee. The following recommendations were made:

1. That examinations made of all relief clients by the C.W.A. several years ago are now too remote to be of any value in laying plans for a rehabilitation program in Minnesota.

2. That the Minnesota State Medical Association will coöperate in such a program if the State Relief Administration believes the program worthwhile; but that it will be necessary to re-examine all relief clients as a first step toward formulating a program.

At the request of the Farm Security Administration, a plan for providing medical care for clients of the administration was drawn up by the committee and is now under discussion. In general, the plan provides for medical care for the clients at a 40 per cent reduction from prevailing fees in the locality to be paid within 90 days. The Administration, according to the plan, is to provide the doctors with names of the clients in their communities and to make it clear to them that medical care at such fees is only by special arrangement for the period of their association with the Farm Security Administration. Similar plans are in operation in other states.

W. A. COVENTRY, *Chairman*

SUB-COMMITTEE ON INDUSTRIAL RELATIONS

The following resolution is submitted by the Committee for action by Council and House of Delegates:

"WHEREAS in practice, the medical profession has always been in favor of the freedom of patients to choose their own medical advisers and

"WHEREAS only recently a law has been enacted in Minnesota giving the indigent the right to choose his own physician and

"WHEREAS there seems to exist an impression that the Minnesota State Medical Association is not fully in accord with this opinion.

"THEREFORE, Be It Resolved that the Minnesota State Medical Association declare itself in thorough accord and support of the principle that, in the interest of good public policy, the patient shall be permitted to choose his own physician, in cases involving liability and compensation insurance, as well as in private practice."

The Committee also recommends to the Council and the House of Delegates that insurance practice and compensation practice be subject to the code of ethics that governs private practice and offers for their consideration the "Interpretation of the Code of Ethics" which has been in force in the Hennepin County Medical Society since April, 1935, which is as follows:

"Physicians representing insurance carriers or employers in compensation cases or in cases involving public liability are expected to observe the rules laid down in Article IV, Section 3, Principles of Medical Ethics of the American Medical Association the same as physicians in private practice. A physician representing an employer or an insurance carrier may visit and examine as a consultant a patient in charge of another physician but should never take charge of or prescribe for the patient until after the other physician has relinquished the case or has been properly dismissed. This consultation should be arranged in the usual way by obtaining the consent of the attending physician. A request by an employer or an insurance carrier that a physician representing them take charge of the case shall not be considered a proper dismissal of the physician originally in charge. A physician representing an employer or an insurance carrier should never take charge of a patient who has been in charge of another physician unless the latter has been definitely discharged by the patient. In that case it shall be the duty of the physician representing the employer or the insurance carrier to explain to the patient that he has the privilege of choosing his own physician and to inquire whether he changed his physician by reason of duress, or intimidation, or misrepresentation. If the patient chooses to retain his own physician, it shall be unethical for the physician representing the employer or the insurance carrier to take charge of the case. Any case of doubt concerning professional judgment or management of the case or ethics as provided in Article 5, Principles of Medical Ethics of the American Medical Association should be referred to the Board of Censors of the Hennepin County Medical Society through the Ethics Committee for final decision."

A plan similar in general outlines to the Wisconsin plan for handling compensation insurance should be presented to the State Association for consideration. It is the opinion of the committee, however, that the problem differs from Wisconsin in Minnesota and it therefore suggests that a register be kept in every local medical society in the state showing the physicians who desire to engage in practice in which insurance companies are involved. Membership on this list would be optional with each physician; but any member in good standing in his local society should be eligible to enter his name. These names need not be posted or published but should be available for reference by employers, insurance companies or patients. Each local society should be privileged to decide whether it would adopt the plan and it should further have the privilege of adopting its own fee schedule.

M. S. HENDERSON, *Chairman*

SUB-COMMITTEE ON CONTRACT PRACTICE

Two years ago the chairman of the Committee on Contract Practice presented to the House of Delegates the standards relating to contract practice as simplified and revised by the Judicial Council of the American Medical Association for adoption all over the state. They were adopted at that time by the delegates and by a number of county and district societies in the state.

A report on the status of this action in all the counties of the state would be appreciated by the committee so that the matter can be presented again to societies that have not already acted.

The association of certain physicians with a fraternal organization which includes medical care in its benefits has been reported as a possible infringement during the past year. In some instances, physicians have been retained by the organization to take care of members and their families, thus introducing a third party into the relationship and also preventing free choice of physician to the patient. In both these particulars such a contract violates the official standard.

The matter has been under consideration by the Committee on Public Policy, however, with the result that the project has already been abandoned in several communities. Assurance has been given that it will be abandoned universally in the state by June 1 of this year.

The importance of the free choice of physician as a fundamental to the practice of good medical care cannot be brought too frequently to the attention of the physicians, in the opinion of the committee, or to the attention of others concerned in the delivery of medical care.

A so-called "hospital service contract" which includes medical services is being offered currently by certain insurance companies. The committee believes that the fee schedule for medical services should be eliminated from the contract and that the whole matter should be brought to the attention of the delegates.

F. A. OLSON, *Chairman*

EDITING AND PUBLISHING COMMITTEE

Although business conditions in 1937 were adverse with regard to the sale of advertising—this applies especially to the last half of the year—your Editing and Publishing Committee reports some increase in the total revenue from advertising and subscriptions.

MINNESOTA MEDICINE averaged almost 100 pages an issue for the year, the total number of pages printed being 1,168. This is an average of 97.3 pages for each issue. Of this number 826 pages were devoted to reading matter and 340 to advertising. The reading pages included 109 scientific articles in addition to several articles and abstracts of articles published in the Proceedings of the Minnesota Academy of Medicine and the Minneapolis Surgical Society, numbering twenty-six in all. Eight case reports were published. This does not include the case reports included in the body of numerous scientific papers. In addition, the usual section features such as editorials, reports and announcements of societies, news items, book reviews and the Medical Economics section were given adequate space. The Medical Economics section this year totaled 79 pages, or an average of 6.6 pages each issue. Illustrations published with the various papers numbered 232, or an average of almost 20 an issue.

At the close of 1937, records showed the total number of paid membership subscriptions to be 2,147, with about 115 subscriptions carried the first part of the year as delinquent accounts. There were 180 non-member subscriptions. Miscellaneous distribution, including single copy sales, exchanges, complimentary copies, advertisers' checking copies, et cetera, numbered 303 copies, leaving a surplus of about 150 copies for possible distribution in filling orders for back copies and for sample copies to prospective subscribers and advertisers. The total average distribution was 2,891

copies. At this time the total has increased to a point where 3,100 copies of the journal are required each month, and it appears that to meet requirements, at least that many copies will be required of each monthly issue during 1938.

Herewith please find a financial statement showing the total income and expense. This shows a breakdown of all the expenses incurred in connection with the publication of the journal during 1937 in every detail.

Effective with January 1, an increase in advertising rates announced more than a year ago, became effective. This should have a good effect upon 1938 income, and it is reasonable to expect, your Committee believes, that the advertising volume for this year should show a substantial increase over that of 1937. Of course it is understood that no definite assurance can be given to this effect owing to the uncertainties of business conditions. Up to and including the June number of this year, we have a net increase in display advertising of $350.00 over the corresponding period for last year, so it seems only reasonable to estimate a $500 or $600 increase for the year in advertising receipts.

The journal is also carrying eight pages in each issue of the Minnesota Medical History. This material is being kept standing in page form for the possible publication of a book after the work has been completed and presented through MINNESOTA MEDICINE. It is felt that the sale of this book will enable the state association to recover all the costs incurred in the publication of the history in MINNESOTA MEDICINE with a reasonable probability of a net profit.

Some economies have been effected and plans approved for a possible increase in revenue from sources other than advertising and subscriptions which your committee is confident will show a larger net return for 1938 than has been earned during the past three or four years.

However, it is only fair, in considering costs and income of your journal, to bear in mind that MINNESOTA MEDICINE is produced in such a style as to reflect a great credit upon the medical profession of this state; that it is well printed on good quality of paper stock, with an attractive cover and good typography throughout. No state journal in organized medicine has a higher standing. It is much better illustrated than the general run of medical publications. Obviously the cost of these illustrations amounts to a considerable sum during the year, but we believe that the membership desires that a high standard be maintained.

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS

MINNESOTA MEDICINE
For the Period
January 1, 1937, through December 31, 1937

SOURCE OF CASH RECEIPTS		
Display Advertising		$ 8,562.20
Member Subscriptions		4,293.50
Non-member Subscriptions		425.20
Illustrations		49.55
Miscellaneous Income		7.83
Bad Accounts Recovered (See Schedule A)		83.05
Dividend		505.85
Gross Cash Receipts		$13,927.18
Less:		
Discounts and Commissions		
Advertising	$1,262.20	
Subscriptions	10.17	
		$ 1,272.37
Net Cash Receipts		$12,654.81
CASH DISBURSEMENTS		
JOURNAL Expense (See Schedule B)		$12,031.38
Cash Surplus for Period		$ 623.43
Accounts Receivable January 1, 1937		$1,096.00
Accounts Receivable December 31, 1937		$1,278.79

SCHEDULE A
BAD ACCOUNTS RECOVERED

Palmer Company	$20.20
Minneapolis Sanitarium	47.00
Willows Sanitarium	15.85
	$83.05

BAD ACCOUNTS CHARGED OFF

Radioear Company	$76.00

SCHEDULE B
JOURNAL EXPENSE

Paper Stock	$ 1,328.38
Printing Expense (Includes composition, make-up, lock-up, press-work, bindery work, addressing wrappers and inserting magazines in mailing envelopes)	5,306.66
Editorial Salary—Dr. Drake	1,200.00
Bruce Publishing Co. Service Fee (Covers business management, stenographic service, mechanical editing of all material, ordering all cuts, making of dummy, mailing all proofs, bookkeeping, billing and collections, keeping up mailing list, etc.)	1,680.00
Bruce Publishing Co. (Telephone, telegraph, addressograph plates, etc.)	132.00
Advertising Commissions (Including 5% received from advertising placed through CMAB)	1,123.14
Illustrations	720.15
Mailing Envelopes	133.26
Second Class Postage	209.54
Stationery	18.55
2% Social Security Tax on labor costs	127.20
Bond—J. R. Bruce—Years 1937 and 1938	50.00
Enlargement of Cover for Exhibit	2.50
	$12,031.38

STATEMENT OF INCOME AND EXPENSE AND PROFIT AND LOSS

MINNESOTA MEDICINE
For the Period
January 1, 1937, through December 31, 1937

	ACCRUAL BASIS	
INCOME		
Display Advertising	$ 8,815.30	
Member Subscriptions	4,293.50	
Non-member Subscriptions	425.20	
Illustrations	49.55	
Miscellaneous Income	13.52	
Bad Accounts Recovered (See Schedule A)	83.05	
Dividend on Advertising from the American Medical Association	505.85	
		$14,185.97
EXPENSE		
JOURNAL Expense (See Schedule B)	$12,031.38	
Discounts and Commissions		
Advertising	1,262.20	
Subscriptions	10.17	
Bad Accounts Charged Off (See Schedule A)	76.00	
		13,379.75
Profit for Period		$ 806.22

J. T. CHRISTISON, *Chairman*

The Reference Committee made the folowing recmendations and comments concerning the reports of the Medical Economics Committee, its sub-committees and the Editing and Publishing Committee:

That the House of Delegates might wish to have more detail as to the progress of the Survey of the Need and Supply of Medical Care than is given in the rather generalized report of the Committee on Medical Economics though the committee realizes that the survey is still in its infancy. A definite stimulus to action seems to be needed since, in some instances, it is understood that the councilors have not yet met with the various local societies to explain objectives and methods.

—That the individual societies should appoint committees of review to analyze and consolidate reports as they come in. The Committee feels that Minnesota is fortunate in having within its ranks the national

chairman of the Survey, that Doctor Braasch has undertaken a tremendous job and that the State Association should make every effort to complete its survey in the spirit in which it has been undertaken.

—That the Medical Economics feature of MINNESOTA MEDICINE is essential and should be continued.

—That the activities of the Sub-Committee on Professional Education in Medical Ethics and Social and Economic Trends should be extended in that members of county and district societies should meet with groups of internes for discussion of these problems while they are on their interne service. The Committee suggests further that county societies make it a part of their program to encourage new members in their communities, to call on them personally and to assist them in becoming acquainted with the relation of all these matters to the practice of medicine and to medical jurisprudence.

—That the Medical Advisory Committee is doing valuable work and the Committee hopes it will be continued.

—That the report of the Sub-Committee on State Health Relations be accepted as submitted.

—That a careful perusal of the report of the Sub-Committee on Low Income and Indigent Problems be recommended to all members. The Committee wishes to thank the Sub-Committee for its classification of indigency and suggests that the compilation of Survey Blanks will be simplified if this classification is followed. The Committee makes note of a new group of citizens forming itself into a position to request medical care at a 40 per cent discount of fees and asks an explanation of who may be included among the clients of the Farm Security Administration.

—That the resolution relative to choice of physicians proposed in the report of the Sub-Committee on Industrial Relations be adopted, also the code of ethics governing insurance and compensation practice and that the report as a whole be accepted.

—That the committee approves the principles proposed in the report of the Industrial Relations Committee and believes that the medical fee schedules presented in hospital service contracts of insurance companies should be considered by the House of Delegates and that such practices should be discouraged.

—That the report of the Editing and Publishing Committee be adopted and that the committee wishes to express its appreciation for the excellence of our state publication. The delegates accepted the reports with the recommendations of the Reference Committee.

Dr. W. F. Braasch, chairman of the Committee on Medical Economics, offered the following supplementary report on the Survey:

I can truthfully assure you, in the first place, that our progress with the Survey in Minnesota compares very favorably with other states in the Union. While the Medical Economics committee has general guidance, the work is largely centered in the office of the Executive Secretary, Mr. Rosell, and really he has done a very good job, proceeding systematically to coöperate to the fullest extent with committees, county societies and with allied agencies.

Only one of the nine survey forms prepared by the American Medical Association has been sent to each individual doctor in the local societies to fill out. The other forms have been sent through state organizations and agencies concerned with the activities in question. On the progress made by these coöperating agencies we can report with some degree of accuracy. The interest exhibited by these organizations and the promptness with which the forms have been filled out and returned is significant and encouraging.

Form No. 1, covering actual experience of individual doctors, has been answered fairly well. Some fail, however, to answer questions 7, 8 and 9, which call for their own solutions as to problems involved. These should not be left blank. There must be a solution to the problems involved in medical care for the indigent and we must have the help of the general practitioner in finding the solution.

Form No. 2 on hospital facilities and activities has been sent to all members of the Minnesota Hospital Association by Mr. A. M. Calvin, secretary. We understand a satisfactory return is coming in.

Form No. 3, concerned with nursing, has been sent for information on public health nursing to Miss Olivia Peterson, director of public health nursing of the State Board of Health, and to the Minnesota Registered Nurses Association for information on private duty nursing. Returns have been received from 35 counties this week by Miss Peterson and from four of the nine districts covered by the Registered Nurses Association.

Form No. 4 covering official health activities is in charge of Dr. A. J. Chesley, executive officer of the State Board of Health and member of the American Medical Association's advisory committee on the Survey, who has sent it to all community and county health officers of the state and received returns from 68 counties and seven communities.

Form No. 5 on public welfare activities is in charge of officials of the State Relief Agency, who have sent forms to relief workers in every county and received returns from 65.

Form No. 6 on health activities in the schools is in charge of the State Department of Education for the public schools. To date, 80 per cent of city and town schools and all county superintendents of the state have returned forms. One hundred and fifty of the 300 parochial schools who received forms direct from the state office have made returns.

Form No. 7 on health services in the colleges also went direct from the state office to the 25 colleges and universities of the state. Twenty-two have made returns.

Form No. 8 on medical service arranged for or provided by industrial, fraternal, mutual benefit, group hospitalization, community health or other similar organizations, or by county medical societies, is being handled direct by the state office.

Form No. 9 on activities and experience of wholesale and retail druggists was received at a later date than other forms, but is now in the hands of the State Pharmaceutical Association, and group meetings are being held in various parts of the state to stimulate interest and returns from the members.

As I have said before, to be accurate and to give a reliable picture of conditions all over the state on which to build improvements or readjustments, this Survey must be honest and it must represent all districts and classes. It was not planned as a statistical exercise but as an earnest and sincere effort to evaluate medical service in every county in the state and, as such, it is of importance to every member. Upon the

accuracy and honesty with which the work is done will depend the future of medical practice in Minnesota.

Dr. B. J. Branton, chairman of the Medical Advisory Sub-Committee, presented the following supplementary report:

First, we wish to commend the spirit of coöperativeness that is becoming more and more evident among our members. This spirit will eventually eliminate virtually all unwarranted malpractice cases in the state.

Second, we call your attention to the lessening of the size of verdicts awarded in malpractice cases during the past year. Many cases, of course, have not been brought to trial at all, even after papers were served. Many others have been settled as nuisance cases for a very few dollars. When it came to settlement, many $15,000 to $20,000 cases have been settled for from $50 to $150.

Third, the committee selected by the Minnesota State Bar Association to work with our committee is doing everything in its power to curtail illegitimate cases. In this connection, I wish to urge all of our members to become better acquainted with members of the Bar Association. Interprofessional meetings should be encouraged and will do much to iron out difficulties encountered by both professions. There are 1,700 members of the Bar Association in the state, men of the same caliber and type as our members, and they welcome an opportunity to become better acquainted.

Contacts with insurance company representatives and this committee have been mutually advantageous, also. The insurance representatives have brought to my attention the following matters which should be considered by all of us.

One is that a great many suits are being brought in order to avoid having to pay medical and hospital bills. The patient is disgruntled and brings suit for malpractice, often as a counter action when he is sued for the bill. In the case of such patients trouble can be avoided by waiting until the 25th or 26th month has passed before putting the bill in the hands of a lawyer.

Another is that many suits are being brought by indigent patients who are looking for easy money. The doctor should be very careful in handling both disgruntled and indigent patients.

A third is that reports for industrial and compensation cases and insurance companies should be made in detail so that the doctor will not be obliged to testify from memory on the witness stand or before a referee. Be sure, also, that you are testifying only as to the facts of the case and that you are not favoring either side. There is always the possibility that the patient may not get as much money as he anticipated from the insurance company and then he may turn and sue for malpractice, especially if the doctor has elaborated too much on the condition of the patient.

The professional testifiers among doctors are becoming fewer in number. Some of them have seen the error of their ways when their insurance has been taken away from them.

Our committee has learned much from our many outside contacts during the past year and we hope to be of service to our members. Any member who is sued should notify the state office at once. He will then receive a questionnaire which should be made out and returned immediately. The committee will then be at your service and every means will be taken to assist you.

Dr. T. H. Sweetser, chairman of the Sub-Committee on State Health Relations, presented the following supplementary report:

I understand that the State Board of Health proposes to establish another public health district in the Southeastern part of the state to include Dakota, Goodhue, Olmsted, Winona and, I think, Mower counties. They propose to establish an Arrowhead district in the Northern part of the state also.

We have discussed the matter of periodic health examinations for Legionnaires with the State Rehabilitation Committee of the Legion and have carefully examined the forms proposed by the Legion to see if they are complete and yet do not entail an excessive amount of work for the physician. We have advised, also, that the details be left for decision with the local medical society and that fees should be fixed in consultation with the local societies. It was agreed that Legionnaires who can afford to pay should be handled as private patients and that the legion would step in and help those who are unable to pay private fees; also that the physician-patient relationship should be preserved and that records should be kept by the physician who would be glad to furnish any information asked for by Legion officials or the Veterans' Administration upon request of the patient.

I am outlining all this so that you may have advance information in case the Legion post in your locality comes to you.

Doctor Piper requested from Doctor Coventry, chairman of the Sub-Committee on Low Income and Indigent Problems, an explanation of the status of Farm Security clients, also who would pay their loans.

DOCTOR COVENTRY: The government lends certain farmers certain amounts of money to maintain them on their farms until they shall be self-supporting. The money is not loaned for crop restriction or anything of that sort; it is merely done in preference to putting the farmer on direct relief.

DOCTOR PIPER: I was wondering if the special fee for examinations for Legionnaires—I understand two dollars was suggested—would apply to Farm Security clients, also. Or is it only for Legionnaires?

DOCTOR SWEETSER: Only for Legionnaires; but they all want a reduced rate. I don't know how the rest of you feel, but I don't believe that examination should be given for anything like two dollars. We are going to refer the fee question, however, to the local societies.

DOCTOR PIPER: The examination calls for blood test, urinalysis and physical examination, does it not? There are more organizations each year asking for special fees. Just now it is the Legion and Farm Security clients.

DOCTOR SWEETSER: I believe the fee for the examination for Legionnaires should be at least five dollars. If the fee is proper and our suggestions are followed I believe we could have no serious objections to the plan.

Doctor Piper also asked for an explanation of the "Wisconsin Plan" mentioned in the report of the Sub-Committee on Industrial Relations. The chairman was not present and the Speaker suggested that the committee make a supplemental report on the subject to be sent to the delegates.

Committee reports designated as "Officer and Council Reports" and reviewed by the Non-Scientific Reference Committee under the chairmanship of Dr. S. A. Slater of Worthington, follow:

REPORT OF THE CHAIRMAN OF THE COUNCIL

The most urgent business of the Council this year has undoubtedly been the reorganization of the state office made necessary by the leave of absence granted to Dr. E. A. Meyerding, who served us so long and so ably as secretary.

Office management was placed in the hands of Mr. R. R. Rosell, who previously served as assistant to Doctor Meyerding and who had established many close and valuable relationships with the official agencies whose activities involve medical care.

This action was taken on the recommendation of Doctor Meyerding at the meeting of July 25, 1937. As executive secretary, Mr. Rosell took over active direction of all organization activities on September 1 under instruction and advice from the Council and committee chairmen. On December 1, Mr. Rosell and Mrs. Sylvia Holliday were duly bonded for handling of funds and transfer of accounts was made.

Hand in hand with office reorganization, a cut in expenditures to keep within the income of our association was undertaken by the Finance Committee of the Council. A new budget drawn up on an annual instead of a biennial basis was recommended by the Finance Committee and adopted by the Council. This budget under which we are now operating provides for a saving over and above routine running expenses of the association of a sufficient amount to wipe out a deficit of recent years. We are living within the new budget and we hope the end of the fiscal year will see us in good financial condition. Thanks are due especially to the Finance Committee for its work in bringing about this essential adjustment.

It was the expressed wish of the Council that our Association should continue to work with the Minnesota Public Health Association just as we work with other health agencies to the end that all public health work in Minnesota should be effective and authoritative. This type of coöperation is a very important part of our function as a state medical association and is now being extended rapidly to include an intimate advisory participation, also, in the lay education program of the Women's Field Army of the American Society for the Control of Cancer.

Women's Field Army: At a joint meeting of the Council, the Committee on Cancer and representatives of the Women's Field Army, an executive committee was formed for the cancer organization to consist of certain designated officers of the State Medical Association, the American Society for the Control of Cancer and the Women's Field Army. The committee is in direct charge of the program of the field army and controls expenditure of funds (see Report of the Committee on Cancer for details).

In addition to routine work of the Council which includes, approval of applications for affiliate membership, ruling upon problems of ethics and organization brought by county societies, approval of expenditures, several notable special actions were taken as follows:

The Herman M. Johnson Memorial Fund was set aside in perpetuity, only the income to be used for the annual memorial lectureship.

An investigation of medical service at Ah-Gwah-Ching, state sanatorium for the tuberculous, was requested by the State Board of Control and assigned to the Committee on State Health Relations of which Dr. T. H. Sweetser of Minneapolis is chairman. A thorough and impartial investigation was made and the present director endorsed with valuable suggestions as to improvements in personnel and equipment needed at the institution. The report was turned over with the approval of the Council to the State Board of Control.

The advice and coöperation of the Council on many other phases of its program was asked of the Council by the Board of Control, including approval of its program for crippled children and for rehabilitation of tuberculous patients and appointment of a special committee to consult with the Department of Public Assistance of the Board on matters relating to standards of disability.

A special committee was appointed at the request of the Minnesota Hospital Service Association to study hospitalization problems in rural districts; inquiries concerning the advisability of approving commercial hospital insurance plans have come to the Council and the Council has been of the unanimous opinion that such approval should never be given, on principle, by members of the profession, noting further that lapses and loopholes have been discovered in some actual policies which might work hardship upon all parties concerned.

A joint committee of the state association and members of the Minnesota State Bar Association was suggested by the latter body and approved by the Council, which delegated the Medical Advisory Sub-Committee of the Medical Economics Committee to represent the medical body in this joint group.

The general plan proposed by the Committee on Diabetes for establishment of a Council on Diabetes of the Minnesota Public Health Association which should unite diabetics and function as an educational body received approval of the Council with the suggestion that, since Christmas Seal funds of the public health association may not be used for diabetes work, the Committee seek aid from other organizations such as the State Board of Health and also of philanthropically minded individuals for support.

Approval of the postgraduate courses now in their second year in obstetrics and pediatrics financed by Social Security funds and directed by Dr. E. C. Hartley, director of the Division of Child Hygiene of the State Board of Health.

The Council agreed to abide by the verdict of the Minnesota Society of Obstetrics and Gynecology on the suitability for public showing of the film "Birth of a Baby," and, as a result, the society having officially approved the film, it was shown to thousands of people at various points in the state this year.

A special committee was appointed to study the question of standards for physiotherapists looking to the possible licensure of this new professional group.

The Council directed all members, old and new, to fill out the new application blanks drawn up to obtain more extensive biographical information from our members, the blanks to be used as the basis for a new biographical file of members in the State Office.

The Council disapproved the suggestion which came from representatives of an out-of-state organization for a formal inter-professional organization in Minnesota, approving instead a letter sent to all county and district societies in Minnesota by Dr. F. J. Savage, chairman of the Inter-Professional Committee, suggesting frequent informal inter-professional gatherings in all localities for the purpose of better understanding and for the joint promotion of community welfare.

The plan for periodic examinations of all Legionnaires was approved in principle and referred to the Committee on State Health Relations for consideration of detail in conference with Legion officials (see Report of the Committee on State Health Relations).

The Council approved joint subscription to *Hygeia* and *Everybody's Health* on a special offer made by the Minnesota Public Health Association by which both magazines will be sent to members of the Legislature this year.

The term of office of the Chairman of the Council was set at three years, the incumbent being ineligible to immediate reëlection to office.

A total of ten all-day meetings were held by the Council during the year requiring a substantial sacrifice of time and money on the part of all. Other officers and committee chairmen also devoted large amounts of time and service to the work of the Association and the Council votes thanks to them for their con-

tribution and also to the Executive Secretary and his staff for faithful and efficient service and splendid cooperation with the Council during the past year.

GEORGE EARL, *Chairman.*

The Reference Committee recommended adoption of the report with the following changes:

—That paragraph five of the report be eliminated and that the following paragraph be substituted (this substitution was submitted by Chairman Earl, himself):

"It was the expressed wish of the Council that our Association should continue to work with the Minnesota Public Health Association. The advantage of the past coöperation between the Minnesota Public Health Association and the Minnesota State Medical Association is fully recognized and it is desirable that the cooperation continue as far as possible."

—That the part of the paragraph on group hospital service referring to commercial hospital insurance plans be eliminated.

—That the following comment should be made on the paragraph on postgraduate courses:

"Although your committee appreciates the value of refresher courses of this type when controlled by the State Association, nevertheless, we believe that other postgraduate courses sponsored by the State Association as in the past should not be neglected."

The delegates accepted the report with the changes and comments recommended by the committee.

REPORT OF THE COUNCILOR OF THE FIRST DISTRICT

Notable activity in the membership and in the component societies was noted during the year.

1. *Care of the indigent.*—County Commissioners have probably been as coöperative as necessities for economy would permit; an insufficient amount of money is available, however, for medical care of the indigent. In addition, relief clients have learned to demand the best and frequently ask for special tests, et cetera, that are not absolutely necessary, thus adding to expense in the individual case.

2. *Syphilis.*—Local health officers have complained of lack of coöperation financially in some instances, on the part of the local medical group, in the treatment of syphilis. County medical societies and local groups may have to make some more satisfactory financial arrangements with health officers if the campaign against syphilis is to be a success.

3. *American Medical Association Survey.*—Component societies in this district have been informed concerning details and some counties in the district have been active in carrying it on. Certain points that may be helpful have been brought out in discussion with physicians.

a. Local health officers may have difficulty in obtaining required information and should consult the State Board of Health on procedure.

b. Local town and village physicians should at some time review blanks filled in by schools, lodges and other local organizations in order to be sure that the local situation has been accurately covered and blanks gathered through state organizations should have approval of local physicians before tabulation is carried out.

c. Patients who are temporarily delinquent in accounts should not be reported as permanent medical indigents since many of these temporary delinquents have paid something on old bills and desire to be financially independent.

4. *Campaign of the Women's Field Army.*—Your councilor assisted in obtaining speakers throughout the district for the campaign of the Women's Field Army of the American Society for the Control of Cancer. The campaign in this district was successful.

Your councilor has been chiefly active during the past year in the study of finances of the Association as chairman of the Finance Committee of the Council. Report of the study is made by the Chairman of the Council.

H. Z. GIFFIN, *Councilor, Fifth District.*

REPORT OF THE COUNCILOR OF THE SECOND DISTRICT

All societies of the second district have been very active this year. All have held many meetings and several individual counties have organized medical clubs which meet six or seven times a year.

Dentists, lawyers and district judges of the locality were present at a well-attended and successful interprofessional meeting held by the Southwestern Minnesota Medical Society composed of medical men from six counties of the district this spring.

The Survey is under way in the district and I expect to be able to give a report of progress at the time of the state meeting.

L. L. SOGGE, *Councilor, Second District.*

REPORT OF THE COUNCILOR OF THE THIRD DISTRICT

Several important district meetings have been held during the past year, notably the meeting at Willmar at which all secretaries and presidents of the component societies met with Mr. Rosell and the Councilor to discuss phases of the economic situation as they affect medicine. Meetings of this type are of value, I believe, and should be held frequently.

The membership in the district has remained practically the same and a tendency to be closer in thought is notable among the members. Altogether, there is an unusually fine feeling, I believe, within the entire district.

B. J. BRANTON, *Councilor, Third District.*

REPORT OF THE COUNCILOR OF THE FOURTH DISTRICT

No complaints have been referred from this district for reference to the Council during the past year. Societies are active and membership somewhat higher than last year.

We have seen an improvement, also, in the handling of medical care for the indigent though conditions are not yet entirely satisfactory and we look to more satisfactory arrangements in all our counties.

J. S. HOLBROOK, *Councilor, Fourth District.*

REPORT OF THE COUNCILOR OF THE FIFTH DISTRICT

All societies of the Fifth Councilor District are active with the possible exception of Dakota County, where the situation is peculiar in that the county is relatively small in population and some of the physicians, being so close to the Twin Cities, are affiliated with the Ramsey and Hennepin County Medical Societies. The Dakota County society is primarily interested in problems related to care of the indigent and other such matters that must be handled on a county basis.

The problem of care of the indigent differs in status in the rural districts from the status in Ramsey County, where long established charitable institu-

tions and agencies have had charge of the work for many years and have, with few exceptions, continued to carry the indigent load. In the country districts, progress has been made in improvement of relationships with official agencies.

The Survey has been presented to all of the societies in this councilor district and here, too, progress is being made, particularly in the East Central and the Washington County Societies.

GEORGE EARL, *Councilor, Fifth District.*

REPORT OF THE COUNCILOR OF THE SIXTH DISTRICT

Forms for the American Medical Association Survey have been placed in the hands of Wright county members by Doctor Catlin of Buffalo, and I am now beginning to receive returns. The entire membership of the Hennepin County Medical Society has received the forms but no returns are available as yet.

The Hennepin County Medical Association has appropriated $1,000 to defray cost of collecting and tabulating results of approximately 10,000 tuberculin tests applied by private physicians in their own offices. This action is, in effect, a tuberculosis survey in private practice for which aid has been requested by letter from both the state and the Hennepin County tuberculosis organizations. If the project is successful I may suggest that a similar survey for the state be carried on under the sponsorship of the state medical association with the aid of the state tuberculosis association and interested parties.

C. A. STEWART, *Councilor, Sixth District.*

REPORT OF THE COUNCILOR OF THE SEVENTH DISTRICT

Both membership and attendance in this district are at a higher level than before, due chiefly to the activities of the secretaries of the two constituent medical societies, Doctor Badeaux and Doctor Libert, and also to a growing interest in the problems of medical economics. Care of the indigent by county physicians obtained formerly in two counties, and in a third county physicians were not paid either by county or township for care of the poor. In one of the two counties, free choice of physician was restored a year ago and in the other it was restored following passage of the "choice of vendor" clause. Negotiations are under way in the first for a better percentage basis for physicians and elimination of certain objectionable features; in the second, the plan is operating much more satisfactorily than before. In the third, there is a prospect of payment for medical services as a result of conferences between township and county officials and committees of the medical society.

The feeling of comradeship among physicians in this district appears widespread and sincere.

E. J. SIMONS, *Councilor, Seventh District.*

REPORT OF THE COUNCILOR OF THE EIGHTH DISTRICT

Satisfactory relations exist between members in this district and between the profession and the public, and, on the whole, between the profession and the relief agencies. The swing seems to me to be towards the profession, generally, rather than away.

This condition can be ascribed to a considerable extent to the efficient work of the society, especially its Executive Secretary and special committees; also, fair treatment accorded the profession by the Governor and the State Relief Agencies, as well as the high standard of service rendered to the people by the profession.

W. L. BURNAP, *Councilor, Eighth District.*

REPORT OF THE COUNCILOR OF THE NINTH DISTRICT

Medical affairs have gone smoothly in the district. Meetings have been well attended, programs have been instructive and papers carefully prepared during the past year.

The Range Medical Society, an affiliate of the county society, has been active, also, holding well attended meetings with varied and interesting programs and conducting, all during the spring, postgraduate meetings with outside lecturers.

The relief situation has been handled as well as could be expected in the past although there are rumors of trouble which we hope will not materialize in the future.

BERTRAM S. ADAMS, *Councilor, Ninth District.*

In compliance with the recommendation of the Reference Committee the Councilors' reports were accepted by the delegates.

REPORT OF THE TREASURER

The officers and Council of the Minnesota State Medical Association have been troubled for a number of years over the increasing deficit in the finances of our Association at the end of each fiscal year. During this year they have undertaken to reorganize our expenditures and set up a budget which should keep our expenditures within our annual income.

You will note on the enclosed auditor's statement, dated December 31, 1937, that an apparent surplus of $2,144.72 appears. This surplus does not represent a true picture of the finances of the organization.

This figure occurs on the books of that date because $3,135.00 had been taken in in dues for 1938 but had already been used to defray expenses for 1937. In addition, the statement shows an item of $1,953.51 in the savings of the American National Bank. In reality, $1,927.42 of this amount represents the money contributed for the H. M. Johnson Memorial lectureship fund which has been set aside by resolution to be used only in promoting that lectureship and does not represent income for the general purpose of the organization. Further, the statement shows a note for $1,000 borrowed from the bank in October, 1937, as *cash receipts.* This loan was necessary to tide the Association over until the first of the 1938 dues should come in. Thus, at the end of 1937, the Minnesota State Medical Association had overdrawn close to $4,000.

The new budget drawn up for 1938 by the Finance Committee of the Council has so reduced expenditures that this deficit will be wiped out, the Association will be able to live within its income during 1938 and have a small surplus at the end of the year.

MINNESOTA STATE MEDICAL ASSOCIATION STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS FOR THE YEAR ENDED DECEMBER 31, 1937

CURRENT FUNDS		
Cash on Hand, December 31, 1936		$ 6,354.83
Cash Receipts, Year 1937:		
Dues collected, year 1936 and prior	$ 216.25	
Dues collected, year 1937	31,134.50	
Dues collected year 1938	3,135.00	
Total dues collected	$34,485.75	
Contributions to Johnson Memorial Fund	343.89	
Sale of diabetes books	84.44	
Bruce Publishing Company (Minn. Medicine)	774.36	
Transferred from Technical Exhibit Fund for credit of Annual Meeting expense	4,534.68	
Borrowed on notes payable	1,000.00	
Interest on savings accounts	54.43	
Dinner tickets (Annual Meeting)	265.69	
Sundry items	20.77	
Total receipts		41,564.01
		$47,918.84

Cash Disbursements, Year 1937:

Special committees:		
Educational Fund	$10,123.52	
Historical	1.50	
Hospital and medical education	58.82	
Medical economics	1,487.82	
Medico-legal advisory	290.81	
Medical relief	272.96	
Public Health education	4,634.21	
Radio	386.22	
State Health relations	159.62	
Unbudgeted committees	1,018.18	
Minnesota Medicine	4,293.50	
Furniture and fixtures	209.30	
Dues refunded	30.25	
Advance to employee	200.00	
Expenses, Johnson Memorial Fund	10.55	
Diabetes books	16.90	
Conferences and meetings:		
Annual Meeting	5,873.83	
Council Expense	412.35	
A.M.A. delegates	235.05	
County society meetings	72.47	
Other conference expense	81.05	
County officers' meeting	366.88	
Special session, House of Delegates	8.03	
Administrative expenses:		
Secretary's salary	2,800.00	
Secretary's travel expense	356.73	
Field secretary's salary	3,600.00	
Field secretary's travel expense	1,776.55	
Field secretary, balance of 1936 salary	300.00	
Treasurer's salary	100.00	
Stenographic service	3,056.55	
Rent	636.00	
Office supplies and printing	838.74	
Postage	531.51	
Telephone and telegraph	729.20	
Miscellaneous expense	805.02	
Total disbursements		$45,774.12

Cash on Hand, December 31, 1937:

American National Bank, Checking account	$ 64.94	
American National Bank, Savings account	1,953.51	
Farmers and Mechanics Bank Savings account	99.45	
First National Bank Savings account	26.82	
Total Cash on Hand		$ 2,144.72

W. H. CONDIT, *Treasurer.*

In compliance with the recommendation of the Reference Committee the Report of the Treasurer was accepted by the delegates with the following change. That the first paragraph should read as follows:

"The officers and Council of the Minnesota State Medical Association have been concerned for a number of years over the increasing cost of conducting the affairs of the State Association and balancing the budget. During this year they have undertaken to reorganize our expenditures and set up a budget which should keep expenditures within our annual income."

The Reference Committee also made note of the following: "In the opinion of your committee, if it should become necessary to secure funds to defray increasing expenses in order to balance the budget, the advisability of a small assessment might well be considered."

REPORT OF THE EXECUTIVE SECRETARY

On July 25, the Council granted the request of Dr. E. A. Meyerding for a year's leave of absence and instructed Mr. R. R. Rosell, assistant to the secretary, to take over the duties of executive secretary of the organization. Subsequently, in the interest of economy, the Finance Committee, with the approval of the Council, also ordered a complete separation of office management from the Minnesota Public Health Association, including a separation of bookkeeping.

This separation was completed as rapidly as possible and the Executive Secretary's office, although still housed as a tenant in the building owned by the Minnesota Public Health Association, has been independently administered to conform to the budget adopted for 1938 by the Council and with the limited office force allowed by that budget.

Recognizing the need for retrenchment, the Executive Secretary's office has endeavored to cut expenses wherever possible without curtailing, in any way, essential activities of the Association. These activities have, in fact, expanded since last September to meet the growing demands made upon the State Medical Association for advice and coöperation by all federal and state agencies concerned in any way in the provision of medical care.

Among the new activities within the State Office itself is the inauguration of a new biographical file of members with the new application blanks duly filled in with requested biographical information as backbone of the file. Magazines and newspapers have been clipped for personal information about members to add to the file, which consists of a stout manila envelope for each member. It has been suggested that the Women's Auxiliary aid by providing a clipping service by members throughout the state.

Following logically upon institution of the new file, the State Office has also assembled a complete set of MINNESOTA MEDICINE since the date of its first appearance in 1918, early issues being the gift of Dr. W. F. Wilson; also a complete set of its precursor the *St. Paul Medical Journal*, gift of Dr. J. T. Christison. Both are now suitably bound. Thanks to these members, the State Office, which should be the repository of many historical records about medicine in Minnesota, is now equipped with a complete file of its publications and with the beginnings, at least, of a biographical file of its members.

Launching the Survey of the Need and Supply of Medical Care in Minnesota is also an important new activity of the last few months reported upon elsewhere in the committee reports.

Tabulation of replies and information secured still remains to be done. Special funds may need to be appropriated to complete the work uniformly without wasteful loss of time.

As a result of action taken by the Executive Secretary and our attorney, Mr. F. Manley Brist, a new ruling on state income tax exemptions has been made permitting Minnesota doctors to claim exemption in making out state income tax statements on expenses incurred in attendance at medical meetings and in postgraduate education.

One of the principal functions of the State Office other than its routine office functions in respect to collection of dues, issuance of membership certificates, maintenance of the roster, has become the maintenance of close contact and understanding between the State Association and the public and private agencies engaged in ministering to the welfare of the needy and the indigent.

In Minnesota, we have had the opportunity to present the enlightened medical point of view in advance of new programs and regulations. The result of this mutual confidence and understanding in the midst of changing conditions is that no hasty proposals for state supported sickness insurance or politically installed coöperatives have emanated from any of the leaders in political or welfare work. Such alternatives have been relinquished in favor of an honest attempt to deal with medical problems fairly and realistically and with the advice of physicians whose interests lie in the advancement of the public good and of medical science and not in the advancement of party machines and political jobs.

The appreciation of all physicians is due to the public officials who have worked so willingly and courteously with representatives of our Association.

The situation with respect to our relations with these officials is in such marked contrast to the situation a few years ago that it would seem to deserve to be marked by the House of Delegates at this meeting.

As welfare work is now organized in Minnesota, virtually all official services with the exception of di-

rect relief and WPA are under the direction of the State Board of Control. The special thanks of our organization should be extended to Mr. C. R. Carlgren, chairman, to Dr. H. E. Hilleboe, director of Services to Crippled Children, and to Mr. R. E. Youngdahl, director of the Division of Public Assistance, for the understanding and good will they have displayed in working with our organization.

Among marked gains made during the past year was the inclusion in the Extra Session Laws of 1937 on relief of the choice of vendor clause which reads that "all counties shall permit free choice of vendor to relief clients for relief orders, provided the vendors chosen conform to the regulations of the Executive Council and of the responsible relief agency."

Equally important was the ruling of the Attorney General on this clause by which the right of a person on relief to select his own physician is established.

Thanks to the firm stand of S.R.A. officials that state aid could and would be withheld from any county that failed to conform to this interpretation even prior to the ruling of the Attorney General, difficult situations have been cleared up in many Minnesota counties. Remaining sore spots are quite likely to be cleared up as a result of the unequivocal ruling of the Attorney General, which ruling was secured largely through the personal effort of Mr. Brist, who has worked in the closest coöperation with the State Office on all phases of our program during the past year.

The actual state of medical relief and public assistance in general, so far as medical service is concerned, is indicated with reasonable accuracy in the booklet called "Facts and Figures" and issued last February by the State Office. Not only case loads and money spent, county by county, are included, but a brief and complete explanation of the functions and source of funds of each of the more or less entangled agencies that make up the welfare picture in Minnesota.

Responsibility for a knowledge of these agencies and functions must be assumed by the individual practicing physician.

The doctor's individual relationship to the community has changed in the last ten years and it is surely as much a part of his practice to know how to direct his patients who need help to the agency that will provide that help as it is to know how to treat the same patient medically. The State Office stands ready to answer inquiries but complete information on the part of the physician, himself, will contribute overwhelmingly to the successful working of the plan for medical care of relief and low income patients in Minnesota.

It is obvious, also, that physicians thus informed will be able to lay their fingers upon weak spots in the system and take the lead in correcting them.

One of the most effective approaches to the problem of medical care for the under-privileged is a vigorous, well-organized State Board of Health, and Minnesota has been exceedingly fortunate for many years in having such a board under the leadership of Dr. A. J. Chesley. Doctor Chesley works closely with the State Office and with the practicing physician.

The Executive Secretary has spent a considerable portion of his time in personal investigation of malpractice cases referred to the Medical Advisory Committee and also in attendance at meetings of county and district societies and at out-of-state conferences such as the Secretaries' Conference of the American Medical Association, the conference of insurance representatives and the Wisconsin State Medical Society at Madison. The State Office also arranged many committee meetings and conferences, the largest of which, outside of the state meeting, is, of course, the annual County Officers' Conference, at which attendance this year was nearly 100.

Membership of the organization is now 2,467 (2,363 active members plus 105 affiliate and associate members), representing an increase of 95 members over last year. There are 3,884 physicians licensed to practice medicine in the state and of the 1,417 who are not members a percentage are not engaged in practice in Minnesota; others are ineligible to membership for various reasons. A special effort should be made to enroll the remaining eligibles this year so as to increase income and cement the strength of the Association in the state.

It is now possible to report that the income from the fine technical exhibit at this meeting will cover all expenses incident to the Duluth meeting. Thus, no funds will be needed from the budget of the Association to finance the meeting. The Committee on Scientific Assembly has arranged a distinguished program and the local arrangements committee under the chairmanship of Dr. Russell J. Moe of Duluth has worked actively and enthusiastically with the committee and the State Office to make the four-day stay in Duluth pleasant and profitable.

Credit is due also to the State Office staff for the efficiency with which they have assumed new responsibilities and carried on the above full program with a smaller personnel and a minimum of extra help. A considerable saving in expenditures for office help has been made as a result over a like period last year.

The current outlook for maintaining accepted standards for medical practice is good. The load of the needy in the state has reached very close to half a million, however, and the relief picture becomes increasingly complicated. Medicine cannot hope to steer a straight course in the confusion of politics and scarcity of funds to meet the needs unless physicians are clear and definite in their public policy and unless they present a united front.

What may happen in Washington or even in our neighbor state, Wisconsin, cannot be foretold now. Whatever may be in store for us in Minnesota depends very largely upon the public spirit with which we shape our policy and advance to meet the need.

R. R. ROSELL, *Executive Secretary.*

The Reference Committee recommended that the report of the Executive Secretary be accepted with the following two notations:

With reference to the paragraph which reads: "The situation with respect to our relations with these officials is in such marked contrast to the situation a few years ago that it would seem to deserve to be marked by the House of Delegates," the Committee said.

"The Committee wishes to commend the progress that has been made and hopes it will continue."

At the conclusion of the report the Committee also added this comment:

"Without wishing to detract in any way from the excellent work of the Executive Secretary, your Committee believes that attention should be called to the fact that much of the efficiency of the Secretary's office is based on a continuation of the activities and system established by the retiring Secretary, Dr. E. A. Meyerding."

The delegates accepted the report and comments.

REPORT OF THE SECRETARY

As your Secretary has been on leave of absence since September 1, 1937, pending acceptance of his resignation, his report will cover briefly certain activities from January 1, 1937, to September 1, 1937. The customary detailed report of the activities of the Secretary's office and Council activities will come from the Executive Secretary's office.

Those who took part in the organization of your

Association in 1924 know how little we had with which to start. To compare the Association at that date with the present Association, the progress, growth, harmony, and united activity that exists, seems astounding. We truly have a great State Medical organization, a fact recognized throughout the United States and making the organization the envy of all of the other states.

This great development is not the work of any one man but of a large group of unselfish, self-sacrificing medical men, and we have many of these left in the organization—the type of man who places the organization before any personal ambitions he may have.

This report would not be complete unless we mention some of this group of great workers who have made your present Association. Among them are: E. S. Boleyn, Charles Bolsta, S. H. Boyer, W. F. Braasch, W. L. Burnap, R. M. Burns, J. T. Christison, L. R. Critchfield, Carl B. Drake, George Earl, M. S. Henderson, H. M. Johnson, Starr Judd, O. E. Locken, the Mayos, J. A. Myers, N. O. Pearce, F. J. Savage, C. L. Scofield, L. L. Sogge, Theodore Sweetser, H. Longstreet Taylor, G. S. Wattam, W. W. Will, H. M. Workman, C. B. Wright, and others whose names will occur to you at this time.

Their hope and our hope is that their efforts will be appreciated and that the present group who are responsible will be as unselfish in promoting the best interests of our State Medical Association as were their predecessors.

Growth of Economic Problems.—With the increasing activity of Federal and State Welfare Agencies, our governmental administrators are becoming more intimately concerned with the health and medical care of the public, and medicine is consequently becoming deeply affected and influenced by these agencies.

We do not intend to go into detail but if you will consider the advances made in medical relief, the extension of the various state departments through federal aid in the care of the crippled and handicapped children, the many medical activities that have become part of the program of the State Board of Control, the increase in the activities of the State Board of Health, extending even to the education of the physician and allied groups, you can readily see that these proposed aids for medical care are only forerunners for more complete socialized medicine.

Therefore, it behooves the medical profession to become as compact a unit as possible so that its experience may be used to the best advantage for the public.

Contact Committees.—Your Secretary believes that the most important single accomplishment in his thirteen years' service in this office, was the organization of the County Contact Committees of three.

The necessity of the profession in each County organizing some kind of a group—may it be a medical club, a contact committee, or call it what you may—is of the utmost importance. This group must take upon itself the responsibility of looking after the interest of the profession and the health of the public within the boundaries of their County.

Public Health Education.—A few years ago, the public health education campaign which the Minnesota State Medical Association was able to put on with the Minnesota Health Association seemed to be a rather extensive program. Today, with the millions of dollars of federal funds being spent directly by the government for the work of the state and other official agencies, it is becoming more and more difficult for groups like organized medicine and the Christmas Seal organization to make their part of the public health education program noticed. Careful thought and planning are more essential now than ever before.

It is with extreme regret that your Secretary has noticed the growing separation of the Minnesota State Medical Association and its committees from the Minnesota Public Health Association. I can assure you, however, that the Minnesota Public Health Association, its officers, Executive Committee and members, will at all times stand ready to coöperate to the fullest extent with the medical profession. I, personally, shall make every endeavor to maintain whatever contact I can with organized medicine.

The relationship between the Minnesota Public Health Association and the Minnesota State Medical Association is emphasized by the medical men in the personnel of its officers and executive committee.

Speakers' Bureau.—One of the outstanding accomplishments of the past thirteen years has been the development of speakers who can satisfactorily present medical subjects to lay groups. We now have a considerable number of medical men who are acceptable to the laity.

One of the principal factors in the development of these speakers has been the College Lecture Course. Another was the short courses in public speaking which were given several years ago in various parts of the state. Many of the profession have now taken up public speaking due to the interest developed.

As time progresses, it will become increasingly important to have more medical men who are qualified to present our problems before lay audiences.

The development of medical speakers for lay groups has, thus far, been confined to scientific lines. Unfortunately, the opportunity to develop speakers on economic problems has not as yet presented itself. This is an important problem which confronts the medical profession now. It should be given immediate attention.

College Lecture Course.—The Minnesota Public Health Association and the Minnesota State Medical Association for the fourth consecutive year have sponsored the Health Lecture Course in colleges throughout the state.

This course consists of four monthly health lectures extending from October through January. College officials have been most enthusiastic in their praise of this project and its effectiveness as a means of student health education.

The Minnesota State Medical Association pays the honorarium and traveling expenses of the physician lecturer. The cost of the 1937-1938 course will be approximately $1,150.00 with an average cost of $16.45 per lecture.

The Minnesota Public Health Association does all the administrative work, the organization, planning, booking of speakers and publicity. A conservative estimate of the value of these services is well over $1,500.00. This may seem expensive. We believe, however, that this course is one of our most valuable programs.

We sincerely hope that the College Lecture Course will be continued as long as the schools wish to receive it.

Annual Meeting.—Some eight years ago, members of the Council and a group of members of the Minnesota State Medical Association suggested that a large institute of some kind which should represent the entire Northwest might be possible and advisable. In accordance with the policy of the American Medical Association, it was suggested that this meeting should be held under the auspices of the State Association. The Secretary was urged to build up such a meeting and attempted to comply.

Records show that the enlarged meetings of the Association since that date have been more and more successful and that the cost has not exceeded that of previous small meetings.

Previous to the 1932 meeting in Saint Paul, much of the annual meeting was conducted under the supervision of the local arrangements committee. This included the

handling of all exhibits, scientific, commercial, et cetera. Beginning in 1932, practically the complete supervision of the meeting was placed in the hands of your Secretary.

Audit—Oct. 4, 1924—Sept. 10, 1925—Local Supervision	
Convention Expense—Minneapolis	$1,775.99
(listed Convention Expense on this audit)	
1926—Convention Expense—St. Paul	1,150.13
(listed Convention Expense on this audit)	
1927—Annual Meeting Expense—Duluth	1,420.38
1928—Annual Meeting Expense—Minneapolis	1,242.08
1929—Annual Meeting Expense—St. Paul	1,921.11
1930—Annual Meeting Expense—Duluth	1,844.80
1931—Annual Meeting Expense—Minneapolis	1,459.13
1932—Annual Meeting Expense—St. Paul—State Supervision	1,513.13
1933—Annual Meeting Expense—Rochester—State Supervision	462.44
1934—Annual Meeting Expense—Duluth—State Supervision	1,544.00
1935—Annual Meeting Expense—Minneapolis—State Supervision	1,711.11
1936—Annual Meeting Expense—Rochester—State Supervision	393.83
1937—Annual Meeting Expense—St. Paul—State Supervision	867.60

Registration: The following comparison of registration is not only interesting but valuable:

Year	*Registration*	*Place*
1924	306	St. Cloud
1925	736	Minneapolis
1937	4256 (including physicians, Women's Auxiliary, exhibitors, members of allied professions attending the Congress of Allied Professions)	St. Paul

The 1937 meeting in Saint Paul will be memorable for many reasons. It gave unprecedented program representation to the scientific, social and economic problems of medicine. No other state medical association has been able to gather together at one time and for such a purpose so many organizations and groups who are today allied in the delivery of medical care to the people. Incidentally the participation in the meeting of so many organizations coming from many states made it possible to secure the St. Paul Auditorium for the meeting without charge—a saving of approximately $1,000 in the cost of the meeting.

Interprofessional Relationship Committee.—You are familiar with the report of the joint session of the Congress of Allied Professions held May 3, 1937, at the Lowry Hotel. Dr. Frank Savage, as chairman of the Interprofessional Relationship Committee, has done an outstanding piece of work. Other efforts are being made along this line that should be followed up.

During the entire period of your Secretary's service, public health meetings and interprofessional meetings of various types, such as meetings between the dental profession, the legal profession, pharmacists, etc., have been held throughout the state. I would urge that such meetings be continued. Invitations should be given to the various county health officers and public workers to sit in with the medical profession so they can get better acquainted.

Committee on Medical Economics.—Minnesota was the first in developing the type of Committee on Medical Economics which has proved so successful. The coordination of the various sub-committees centralizes and makes possible a uniform and conservative program in our state.

We have been fortunate in having had as chairman, W. F. Braasch, M.D., whose long experience in medical economics, both state and national, and well known executive ability have been invaluable in keeping us in close touch with happenings in this field throughout the country.

Committee on State Health Relations.—Your chairman of the Committee on State Health Relations is not only very competent, but a very energetic and thorough chairman. Theodore Sweetser, M.D., of Minneapolis, has done a splendid job. He has devoted unlimited time and effort to our Association. We owe a great deal to Doctor Sweetser.

New Constitution.—Your new constitution is not only one of the most advanced, but it has many unique features. The various graphs, showing the functions of the various committees, give at a glance the operation of our Association.

Every member should look over this constitution. It is a truly noteworthy document and is being copied by many other state organizations. In the main it was adapted from the constitution of the American Medical Association, especially in regard to the duties of the president and other high officers.

Housing Minnesota State Medical Association.—For almost fourteen years the Minnesota State Medical Association has been housed with the Minnesota Public Health Association. The administration of these two has been as one. We believe that this arrangement has been to the benefit of all.

Radio Broadcasting.—The Minnesota State Medical Association is unusually fortunate in having two members who are especially interested in radio broadcasting.

R. M. Burns, M.D., chairman of your Radio Committee, is not only interested, but is well informed and has done much to put our radio program in the foreground. Doctor Burns is well able to meet any situation that may arise in the radio program.

Wm. A. O'Brien, M.D., is the foremost health commentator in the United States and we are very fortunate to have such a gifted speaker devoting himself to the dissemination of authentic health information.

Tribute to Dr. H. M. Workman.—Everyone who has been closely associated with the Minnesota State Medical Association during past years appreciates the great sacrifices and worth of that grand old man, Dr. H. M. Workman. Throughout his professional career he was intimately associated with guiding the policies, finances and management of this organization.

During that time his experiences taught him much regarding the medical profession, its members and the relationship with the public.

He was very fixed in certain of his policies, especially regarding the finances of your organization. As I grow older, I appreciate more and more that this attitude came from the wisdom of his many years of experience.

It was Doctor Workman who always believed that the medical profession should be organized as county units. Your county contact committees are an adaptation of his belief. He believed that the medical dues and funds were the most precious treasure that the medical man possessed and must be guarded in every possible manner.

All of us would do well at the present time to follow closely the policies of Doctor Workman. Personally, I am grateful to have had Doctor Workman as my medical economic preceptor.

Financial Obligations.—For more than 13 years your Secretary has had practically complete responsibility of the business and office details of your organization, the only exceptions being the Committee on Public Policy and Legislation, Chairman, Dr. H. M. Johnson and now Dr. L. L. Sogge, and the Publishing and Editing Committee of MINNESOTA MEDICINE. The Council usually met four times a year. Policies were formulated by the Council at its meeting and in the interval by your officers.

The Finance Committee of the Council has had direct supervision of the making of the Budget and has been directly responsible to the Council for the expenditures of the same. Other expenditures required a vote of the Council as a whole.

The only protection against political, legislative and governmental experimentation, including national, state and local, is that provided by your membership dues,

which amounts to some thirty thousand dollars—a very insignificant sum to pay for an insurance premium to protect the health of the public and the standing of our profession.

We used what we thought was the greatest economy and efficiency in handling your funds and affairs. I am proud of my record, and I am proud of the resolution passed by your Council as published in MINNESOTA MEDICINE in January, 1938.

It has been reported that some of you have said that the affairs of our State Association are a small business because only thirty thousand dollars is involved, but let me tell you that it is by far the most vital business in the state as far as the interests of the medical profession and the individual doctor are concerned. It is the only protection the doctor has against the inroads on his freedom and the attacks that are being made on him today in his relation to the public.

Insurance Premium.—The Minnesota State Medical Association has about 2,500 members from the total of more than three thousand medical men practicing in Minnesota. A conservative estimate of the cost of preparing a medical man to practice is at least fifteen thousand dollars; it is probably much more. The profession has an investment of some forty-five million dollars in the original preparation to practice medicine.

In addition, there are many hospitals, clinics, and other institutions that are dependent upon the medical profession. Your medical school, University Hospital, Mayo Clinic, State institutions, church institutions, hospitals, are all more or less dependent on the independence and successful future of the medical profession. Undoubtedly the total investment dependent upon the medical profession runs into hundreds of millions of dollars in Minnesota.

You will agree that every precaution, every effort and the best possible personnel should be sought to protect medical care of the people of Minnesota.

Finance and Reserve Fund.—During my term of office, the expenditures seldom exceeded our income. Most of the budget items, supervised by your Secretary, were underspent. At each Council meeting regular reports of the budget and finances were submitted. The Finance Committee of the Council received special reports in addition. It was necessary to borrow money only twice to tide over the year end. Your auditors, Shannon & Byers, in their annual audits, including 1936, stated: "The books and records of account are adequate for the needs of the Association and have been neatly and accurately maintained."

The Fiscal Agency account was increased some $20,000 odd. Special credit belongs to Dr. Frank Savage during his term as Chairman of the Finance Committee, and Dr. C. B. Wright as Councilman, for the growth of reserve fund. To Dr. H. Z. Giffin, Chairman of the Finance Committee since 1932, belongs the credit for his interest and study of the investments of this fund. We believe that the Fiscal Agency Fund should be several times the present amount.

Conclusion.—The finances, both current and reserve, should receive the most careful attention. Every effort should be made to increase both, to meet the many emergencies that will arise.

The strength of the medical profession lies in its unity. No other group has the training to care for the health of the public as ours has. Consequently, a solid front will permit our profession to guide its own destinies and protect the health of the public.

The medical student should have some training in medical ethics, economics and public relations.

Every medical unit, no matter how small, must appreciate its importance in the problems that confront the medical profession today. These problems may be local or national.

Small groups increase their strength by alliances. Every opportunity must be taken by our profession to have the public appreciate our importance in the social and political organization.

Those responsible for the leadership should leave no stone unturned in protecting our interests both inside and outside the organization.

E. A. MEYERDING, *Secretary*

In compliance with the recommendation of the Reference Committee the report and also the resignation of the Secretary to take effect at once were accepted by the delegates.

Chairman S. A. Slater read the resignation of Doctor Meyerding as follows:

It is with deep regret that I tender my resignation, to become effective at once, as Secretary of the Minnesota State Medical Association. You are cognizant of the fact that I submitted my verbal resignation May 5, 1937, and that I have been on leave since September 1, 1937, and I now deem it wise in justice to myself to make this leave permanent. In justice to the organization, I ask the House of Delegates to accept my resignation this evening so that some one can be elected this week to fulfill the office.

In the summer of 1924, I unofficially assumed the duties as your Secretary. On the first of January, 1925, I officially became your Secretary, a period of practically fourteen years in which I served as executive officer of the Minnesota State Medical Association.

I look upon my work with the Medical Association during these years as the happiest and most interesting in my life. The friendships that have come about through close association in the work will mean much to me throughout my life. I wish to take this opportunity to extend thanks to the members of the Medical Association for the fine coöperation which made it possible for our organization to develop into one of the most progressive in the country. I wish especially to thank the officers and members of the Council and others who have given long hours and much energy in volunteer service.

I am proud of my association with the Minnesota State Medical Association and the American Medical Association and my profession. It is a satisfaction to have been of some assistance in solving our many problems, organizing, developing, and aiding in establishing before the Minnesota public the greatness of our profession.

While I am now stepping out of official service with the Medical Association, my interest and coöperation in the work will continue. Some of you will remember that in my earlier years I frequently paraphrased Decatur's memorial speech as follows:

"Our profession, in her intercourse with those outside, may she always be in the right; but right or wrong, our profession."

I shall always adhere to this precept.

At all times I shall be at your service, and shall be only too happy to assist in any way possible. In leaving, I urge close coöperation and harmony in order that our Association may continue to keep its place of leadership.

E. A. MEYERDING, *Secretary.*

The Non-Scientific Reference Committee on reports designated as "State Health Relations reports," of which Dr. A. H. Zachman of Melrose was chairman, reported as follows:

INTERPROFESSIONAL RELATIONSHIP COMMITTEE

Our major objective has been to foster establishment of local interprofessional relations committees in every county. In the past two or three years the state committee has met with groups of nurses, pharmacists and hospital administrators for the discussion of common problems. Valuable as these meetings have been in the

creation of better feeling and better understanding, it has been the feeling of the committee that the value would be greater if the same type of meeting could be extended to every county of the state. These local interprofessional meetings could render major service in the preservation of medical standards in times of legislative stress, in spreading sound doctrine to offset possible radical demands for state medicine, in backing the American Medical Association in their present study of medical care and, later, in their conclusions on the solution of the problem.

At a meeting of nurses in Minneapolis, attended by your chairman, government aid to tax-supported hospitals for the purpose of paying salaries of nursing instructors was advocated by the state director of education. This program was proposed on the basis of a report by his department on nursing education in Minnesota. The average nurse, according to this report, appears to be a downtrodden individual who sometimes works 84 hours a week, is poorly fed, badly housed, exploited and inadequately trained by the hospital and who graduates with health seriously impaired and without proper education. Not all hospital people or superintendents of nursing agreed with the report. One of the latter agreed that it might be true in isolated cases but that, in general, the report was incorrect. Mr. Amberg, superintendent of the University hospitals, showed that nursing education has been improved, hours reduced and curriculum revised, with students rotating on the various services. Cost of training has increased at the University hospital by $20,000.

At Nassau hospital in Mineola, Long Island, four graduate Minnesota nurses were found recently to be in charge of departments because, according to the chief of staff, "they seem to be the best trained women we can find."

A number of grievances from pharmacists were brought out in discussion following an address by the chairman before the Minnesota State Pharmaceutical Association, April 26. It was suggested that these grievances should be ironed out locally in interprofessional meetings between doctors and pharmacists; also that, although they had been informed two years ago that space would be allowed them to discuss these matters in MINNESOTA MEDICINE, no advantage had been taken of the offer.

F. J. SAVAGE, *Chairman.*

In compliance with the recommendation of the Reference Committee, the report was accepted by the delegates with following comments by the Reference Committee.

"We feel that the meetings sponsored by the Interprofessional Relationship Committee will work to the mutual satisfaction and benefit of all interested groups, namely, nurses, pharmacists, hospital administrators and dentists and also the legal profession, which happened to be left out, perhaps inadvertently, by the committee, but which we shall like to add to the group.

"We feel, also, that the report on nursing education in the state is decidedly biased and does not represent the true condition in the field of nursing education. We recommend that the delegates familiarize themselves with this nursing education report so that they can discuss it intelligently if the need should arise."

CHAIRMAN SAVAGE (supplementary report): One cannot read Doctor Earl's report or Mr. Rosell's report without being impressed with the fact that we can do much for the future of the medical man by these friendly get-togethers. The plan for these local interprofessional meetings met with the approval of the Council. The purpose is to create good feeling and an intelligent understanding of medical problems and the result should be the creation of a friendly body of people throughout every county in the state which should be of tremendous assistance in the shaping of our public policy. I know of two such meetings, one in Doctor Sogge's district and the other in Winona. There may have been more.

DOCTOR SOGGE (speaking at the request of the Speaker): Eighty-eight were present at our interprofessional meeting in Worthington, including the judge of the district. I agree with Doctor Branton that an intimate relation between the doctors and the attorneys in a community is a fine thing. The attorney who knows the doctor's problems is not going to be so quick to start a lawsuit in town, even though it may appear to be a chance to make some money. I am very enthusiastic about interprofessional meetings and so, I believe, was every doctor, druggist and attorney who attended our meeting. We are going to try to have one every year.

DOCTOR GIFFIN: I have a communication from Doctor Wilson of Lake City telling of a meeting held there by their interprofessional relations committee, attended by fifty people, including physicians, dentists, nurses, pharmacists, hospital executives and representatives of the various relief agencies. The problem of medical care for the indigent was discussed. Every profession and agency was represented by a speaker and a much better understanding was created on their joint difficulties.

DOCTOR WILSON (speaking on the subject at the request of the Speaker): We had a worthwhile meeting with the pharmacists at Winona this year. Two speakers from the state pharmaceutical association spoke, and we discussed each other's points of view and enjoyed the whole meeting very much. Six months later the pharmacists invited us to a meeting with them. The meeting was addressed by medical men and valuable discussion followed. I think these meetings should be promoted throughout every county in the state.

An oral report on the work of the Committee on Public Policy was given by Doctor Sogge, chairman, and Mr. F. Manley Brist, attorney for the Minnesota State Medical Association, and accepted by the delegates. No transcription was made of this report.

No report was presented by the Committee on University Relations.

The Necrology Report was presented as follows by Dr. Richard Bardon, representing the Historical Committee:

NECROLOGY REPORT

During the last year, the Association lost forty-four members by death. Thirty-six of these were active members and eight were formerly active members or members who had retired from the Association. The list of deceased members follows:

MEMBERS

Carl M. Anderson, Rochester; J. Fowler Avery, Minneapolis; John T. Bowers, Bemidji; Charles W. Bray, Biwabik; Edward J. Brown, Minneapolis; Charles P. Dolan, Worthington; Charles A. Donaldson, Mesa, Arizona; Frederick C. Drenning, Duluth; Julian A. DuBois, Sauk Center; George Edward, Canton; Martin J. Fiala, Duluth; Herman W. Froehlich, Minneapolis; John J. Gelz, St. Cloud; Clarence W. Golden, Tyler; Frank B. Hicks, Grand Marais; Earl Jamieson, Walnut Grove; DeWitt C. Jones, St. Paul; Raymond W. Lagersen, Minneapolis; Hans M. Lichtenstein, Winona; Frederick W. Logan, Blue Earth; Elias P. Lyon, Minneapolis;

Martin L. Mayland, Faribault; Patrick H. Mee, Osseo; Clarence R. Morss, Zumbrota; Henry T. Norrgard, Milaca; Homer F. Peirson, Austin; Donovan Penheiter, Bagley; Ralph St. J. Perry, Minneapolis; Clarence E. Persons, Marshall; William C. Portmann, Jackson; John T. Rogers, St. Paul; Philemon Roy, St. Paul; Roy A. Schnacke, McGregor; Oscar H. Ternstrom, Minneapolis; Henning F. B. Wiese, Minneapolis; Warren Wilson, Northfield.

FORMER MEMBERS

Frederick H. Aldrich, Belview; George S. Cabot, Jamestown, North Dakota; F. Emerson Daigneau, Austin; Joseph E. H. Garand, Dayton; Amos Leuty, Morris; Ira M. Roadman, Minneapolis; Jorgen G. Vigen, West Los Angeles; James D. Weir, Beardsley.

At the request of the Speaker, the delegates stood with bowed heads for a moment in tribute to the memory of these deceased members.

NATIONAL HEALTH CONFERENCE

Following announcements of the next day's committee meetings the Speaker introduced Doctor Abell, president of the American Medical Association, who spoke as follows:

Mr. Speaker, members of the House of Delegates: Perhaps you will be interested in the background of the National Health Conference which is meeting in Washington, July 18, 19 and 20.

As most of you know, we have been advocating a federal department of health headed by a cabinet minister since 1875. The request has been made to successive administrations and refused on the ground, I believe, that the money expended by federal health agencies did not justify creation of a separate department. The validity of this excuse may be doubted when we consider the various agencies of the federal government today whose functions involve health or medical care. Of the beds available for medical care in this country, approximately a million are controlled by government agencies, including state and municipal governments. In addition, of course, there are the public health functions in the charge of the Department of the Treasury; the food and drug administration of the Department of Agriculture; the maternal and child welfare agencies of the Department of Labor; the Coast Guard Service in the Department of Commerce; Indian welfare in the Department of the Interior; medical service for the Army and Navy under the War Department; medical service for veterans under the Veterans' Administration; and there are also medical functions involved in the work of other bureaus such as the Resettlement Administration and the WPA. The aggregate expenditure for all these must amount to a considerable sum.

The result is that an Inter-Departmental Committee has been appointed during the present administration in Washington to recommend ways and means of coordinating all of the health and welfare activities of the federal government. This committee consists of representatives of five departments; Agriculture, Labor, Commerce, the Treasury and the Social Security Board. The chairman is Miss Josephine Roche. A technical committee on medical care was appointed by the committee and it was under the auspices of this technical committee that the National Health Survey, carried on almost entirely by WPA workers, was made. This survey, designed to present a cross-section of the country, was carried on, I believe, in only nineteen states.

The report of the Inter-Departmental Committee was presented to the President in February, and whether or not one agrees with all of the suggestions and data contained there it is one, I think, which should be considered carefully by everyone who is interested in the health movement in this country.

It starts by paying a tribute to the medical profession for its accomplishments in bringing about the decrease in mortality and the increase in longevity. It then takes up special problems in the control of various communicable diseases. Tuberculosis can be reduced 50 per cent below the present level, for instance, by correcting conditions in industrial life that tend to make people susceptible to it, according to the report. Syphilis, malaria and diseases of childhood are considered; also the degenerative diseases of advancing age—cancer, diabetes, arteriosclerosis, arthritis, nephritis—in relation to the income of the various groups of the population, pointing out what has long been patent to every thoughtful person, that the amount of disease is much higher among the lower income and indigent group than among those of higher incomes above $3,000 a year.

The fact that adequate fuel, food, clothing and shelter may in themselves be a factor in the health of people in the lower income brackets is not considered.

The number of physicians in the country is considered to be adequate by the report, though better distribution should be made. The number of dentists, now about 70,000, is believed to be only about half the number required, and hospital beds are inadequate. In the larger centers, of course, hospital beds are considered abundant for the needs, but the statement is made that in rural communities there are some 18,000,000 people who live thirty miles or more from the nearest registered hospital. This last finding is not in harmony with findings of the bureau of medical economics of the American Medical Association, which show that there are only thirteen counties in which the population density is five to each square mile and the total population, some 68,700 in which the people live thirty miles or more from a registered hospital.

The report considers that public health nurses should be increased from 18,000 to 65,000; that hospitals and diagnostic services should be made within easy access of all communities.

The entire program of recommendations should be met by tax funds or Social Security funds, according to the committee.

Some further interesting observations by Miss Roche made in an address in New York before the American Public Health Association, indicate that the 40,000,000 people in the United States whose family incomes are less than $1,000 a year are considered indigent by the committee. The group of 50,000,000 with family incomes of less than $2,000 are considered medically indigent; in other words, they are able to buy food, clothing, shelter, but not medical care.

One may, perhaps, differ with Miss Roche in this matter. In New York City, $2,000 a year may well constitute medical indigency. In some communities, however, $2,000 constitutes independence and in others affluence. Thus, I am sure we cannot all subscribe to the statement that the 50,000,000 people with an annual income of $2,000 are medically indigent. Furthermore, one does hate to believe that 90,000,000 out of the 130,000,000 people in this country are worthy objects of federal bounty and medical service. I know of no way to reach an estimate of the cost of such service to 90,000,000 people, though possibly costs of medical service to government employes in the Canal Zone may provide an indication.

As you know, all of the inhabitants of the strip of land ten miles on either side of the Canal, together with Cristobal on the East and Balboa on the West, are government employes. There are no indigents and no one who has not adequate food, clothing and shelter. The government provides complete medical services at a cost, without including construction and equipment costs, of approximately $25 a year per person. To provide such care for 90,000,000 people would cost $252,000,000 a year without considering for a moment the funds needed for construction and maintenance of buildings and equipment.

Now the Inter-Departmental Committee has called a

conference to be held in Washington to present, according to the invitation, ways and means to prevent loss of efficiency in our people from illness and for reduction of economic burdens caused by illness. Also, proposals embodying such a program to be made to representatives of the government.

Of course, nobody knows what those proposals will be. I feel, however, that this conference will enable us to know what the attitude of the government toward the practice of medicine will be, and I sincerely hope that some proposal will be made for the improvement of the condition of the indigent, at least, upon which all of us may agree.

The following resolution proposed by Dr. B. A. Smith of Crosby was adopted by the delegates.

"The House of Delegates of the Minnesota State Medical Association wishes to express its appreciation to Mr. C. R. Carlgren, chairman, and through him to Mr. B. E. Youngdahl, Director of the Division of Public Assistance, and to Dr. H. E. Hilleboe, Director of Services for Crippled Children, as well as the entire State Board of Control for their sympathetic and intelligent understanding of medical problems of Minnesota, and for their fine coöperation with the Minnesota State Medical Association in the handling of all medical phases of their work."

The following resolution was proposed by Doctor Zachman and adopted by the delegates with the suggestion that the name of Dr. S. E. Gilkey, medical advisor of the State Relief Agency, be included in the resolution.

"The right to choose his own physician is recognized as fundamental to good medical care for all classes of patients, and the thanks and appreciation of all physicians are due especially to Mr. Aufderheide and his associates of the State Relief Agency for the vigorous manner in which they have interpreted and enforced the provision of the new relief law guaranteeing this right to relief patients in Minnesota. Appreciation is also due to these officials for the readiness and understanding with which they have assisted physicians wherever possible to improve the standards of medical care for the needy."

Following reports by the delegates to the American Medical Association, Dr. W. F. Braasch, Dr. J. T. Christison and Dr. W. A. Coventry, of the meeting of the American Medical Association in San Francisco, the meeting adjourned to be re-convened at 6 p. m., Wednesday, June 29, 1938.

HOUSE OF DELEGATES

Second Meeting
Wednesday, June 29, at 6 p. m.

By motion duly made and seconded it was unanimously agreed to dispense with reading of the minutes of the last meeting.

The Council having no further report for the House of Delegates, the Speaker called for announcements of the next day's events.

The following resolutions were proposed by delegates and adopted by the house:

"The interest and devoted effort displayed by every member of the St. Louis County Medical Society, and particularly by the committee on local arrangements, has added materially to the value of our program and to the comfort and convenience of all who are in attendance at this great meeting. The thanks and appreciation of this House and also of the Association are hereby extended to them for the splendid arrangements made by them for this meeting."

"In its generous contribution of space for our sessions and in its courteous attention to the comfort of our members, the Hotel Duluth has contributed greatly to the success of this meeting. The thanks of the House of Delegates is hereby extended for this service."

"Proper newspaper reports of the proceedings of a state medical meeting add greatly to the interest of our members and they serve also as an important avenue of public education on public health. The House of Delegates extends its appreciation to the *Duluth Herald and Tribune*, especially, and to other Minnesota newspapers for their generous contribution of space to information about this meeting."

* * *

"An unprecedented amount of radio time has been put at the service of our Association at this meeting by stations WEBC and KDAL, not only for advance announcements, but to permit the public to listen to our distinguished guests on medical problems of interest to audiences. The thanks of this House is extended to both stations for their fine coöperation in this matter."

* * *

"The thanks of the House of Delegates should also be extended to the Duluth Chamber of Commerce for their excellent coöperation in all of the arrangements for this meeting and for the efficient help they have given us in registration of members."

* * *

"The thanks of the House of Delegates should be extended to the Minnesota Arrowhead Association for their courtesy in extending the facilities of their offices in the Hotel Duluth for this meeting and for their contribution to the pleasures and comfort of those who attended the meeting."

* * *

"The thanks of this House should be extended to the Kiwanis Club of Duluth for their courtesy and friendliness in presenting the beautiful basket of flowers for our platform."

ELECTION OF OFFICERS

The Speaker then called for nominations for the office of president-elect.

Dr. George Earl of Saint Paul was nominated for the position of *president-elect* by Dr. R. B. Hullsiek of Saint Paul in behalf of the delegates from the Ramsey County Medical Society.

There being no further nominations, it was moved, seconded and carried that the nominations should be closed and that the secretary should cast a unanimous ballot for Doctor Earl for the office of president-elect.

Dr. J. C. Jacobs of Willmar was similarly nominated for the position of *first vice president* and, there being no further nominations, it was moved, seconded and carried that the nominations be closed and that the secretary be instructed to cast a unanimous ballot for Doctor Jacobs for first vice president.

Dr. A. M. Hanson of Faribault was nominated for the position of *second vice president* and, there being no further nominations, it was moved, seconded and carried that the nominations be closed and that the secretary be instructed to cast a unanimous ballot for Doctor Hanson for second vice president.

Dr. B. B. Souster of Saint Paul was nominated by Doctor Hullsiek for the position of *secretary* to fill out the unexpired term of Doctor Meyerding, whose resignation had been accepted by the House, and also to serve for the year 1938-39. There being no further nominations, it was moved, seconded and carried that the nominations be closed and that the secretary be instructed to cast a unanimous ballot for Doctor Souster for secretary.

Dr. W. H. Condit of Minneapolis was nominated to succeed himself for the position of *treasurer* and, there being no further nominations, it was moved, seconded and carried that the nominations be closed and that the secretary be instructed to cast a unanimous ballot for Doctor Condit.

Dr. A. W. Adson of Rochester and *Doctor Will* were nominated for the position of *speaker of the House of Delegates.*

Dr. Joel Hultkrans, vice-speaker, was asked by Speaker Will to take the chair and, upon Doctor Adson's request that his name be withdrawn from the nomination, it was moved, seconded and carried that the nominations be closed and that the secretary be instructed to cast a unanimous ballot for *Doctor Will* to succeed himself as *speaker of the House of Delegates.*

Doctor Will resumed the chair and *Dr. E. A. Meyerding* of Saint Paul was nominated for the position of *vice speaker.* It was moved, seconded and carried that the nominations be closed and that the secretary be instructed to cast a unanimous ballot for Doctor Meyerding for vice speaker.

Dr. H. Z. Giffin of Rochester, *councilor of the first district, Dr. L. L. Sogge* of Windom, *councilor of the second district,* and *Dr. B. S. Adams* of Hibbing, *councilor of the ninth district,* were nominated to succeed themselves as councilors of their respective districts. It was moved, seconded and carried in each case that nominations be closed and that the secretary cast unanimous ballots for each as councilors.

Dr. E. M. Jones of Saint Paul was nominated as *councilor of the fifth district* to succeed Dr. George Earl, previously elected to the position of the president-elect, and it was moved, seconded and carried that the nominations be closed and that the secretary be instructed to cast a unanimous vote for Doctor Jones as councilor of the fifth district.

Nominations were called for to fill the positions of two *delegates to the American Medical Association* with their *alternates* whose terms expired.

Dr. W. F. Braasch of Rochester and *Dr. W. A. Coventry* of Duluth, and *Dr. W. L. Burnap* of Fergus Falls, alternate to Doctor Braasch, were nominated to succeed themselves. It was moved, seconded and carried in each case that the nominations be closed and that the secretary be instructed to cast a unanimous ballot for each.

Dr. Joel Hultkrans of Minneapolis was nominated to succeed Dr. George Earl as *alternate* to Doctor Coventry and it was moved, seconded and carried that the nominations be closed and that the secretary be instructed to cast a unanimous ballot for Doctor Hultkrans for the position of alternate to Doctor Coventry.

PLACE OF MEETING

Invitations from the Hennepin County Medical Society from Dr. J. M. Hayes of Minneapolis, president of the Minnesota State Medical Association, and from the Minneapolis Civic and Commerce Association to the Minnesota State Medical Association to hold its 86th Annual Meeting in Minneapolis were presented by Dr. C. A. Stewart, councilor of the sixth district.

It was unanimously voted to hold the 86th Annual Meeting in Minneapolis.

* * *

In the absence of Dr. A. J. Chesley, secretary and executive officer of the State Board of Health, Doctor Adson was asked by the speaker to give a report of the morning meeting of the State Board of Health.

DOCTOR ADSON: I am sorry, Mr. Speaker, that Doctor Chesley is not here to give you the details of the meeting. The chief subject under discussion was the additional federal appropriation for control and treatment of syphilis which will be put at the disposal of the State Board of Health. I haven't the figures with me but I believe the amount is approximately $42,000. No great expansion in the work of the board can be carried on, as you know, until the present building program is completed. After that, it is the plan to add two assistants (clerks and technicians) with the intentions of using the money only to advance the present program.

Those of you who heard Doctor Irvine today fully appreciate the fine program carried on in Minnesota by the State Board of Health and also the fine interest and coöperation of the board with organized medicine. The fact that the State Board of Health is willing to coöperate with us and to listen to the problems that confront us in the practice of medicine is one of the finest compliments that can be paid them. It is our hope that the medical men in the rural communities particularly will likewise coöperate with the board in its work.

It has been proposed that the new funds be used in some instances to assist those who have no money so that the doctor can be compensated for his work in the treatment of syphilis. At the present time, it is not the intention, as I understand it, to set up any additional clinics anywhere in the state for treatment of syphilis. Instead, the facilities already in existence will be utilized and the general lines of the program that has been in existence here for some twenty years will be followed. Perhaps, Doctor Braasch has something to add on this subject.

DOCTOR BRAASCH: I don't know whether we all appreciate what a valuable man Doctor Chesley is in this community. He is president of the national association of health officers and undoubtedly the outstanding man in the departments of health of the country today. He has received many offers to go to other branches but has elected to remain here. And his work in maternal and child welfare and in child health, as shown by the statistics, is a record in itself. If you visit the State Board of Health exhibit in one of the booths at this meeting you will see what progress has been made in this state.

Furthermore, Doctor Chesley has coöperated fully with the medical profession here and has worked for our joint interests in Washington. I think it no more than right that this House of Delegates should extend a vote of confidence and thanks to him for his work in our behalf and on behalf of the public welfare.

DOCTOR SWEETSER: In seconding this motion, I would like to mention the fact, as chairman of the Committee on State Health Relations, that Doctor Chesley has invited a member of our committee to each Board of Health meeting since the formation of the committee. He has worked hand in hand with our committee all of the time.

The vote of thanks was unanimously carried by the House of Delegates and the meeting adjourned.